



PELVIC & ORTHOPEDIC

PHYSICAL THERAPY SPECIALISTS

Date: _____ Account #: _____

Patient Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

*Which number(s) is our staff authorized to leave phone messages?

Home _____ Cell _____

Date of Birth: _____ SS#: _____

Sex: M F Marital Status: S – M – D – W Email _____

In Case of an Emergency Call: _____

Name Relation to Patient _____ Phone _____

Patient Employer Name: _____

Address: _____

Phone: _____ *May we contact you at this number? Y ___ N ___

Insurance Company Name: _____

(for internal use: benefits verification completed _____)

How did you hear about us?: (mark all that apply)

___physician ___self-research ___internet ___advertising (type _____)
___friend (name _____) ___other _____

Referring Physician's Name: _____ Phone _____

Physician's Address: _____

Name of Primary Care Physician: _____

Women: Name of OB/GYNE: _____



PELVIC & ORTHOPEDIC
PHYSICAL THERAPY SPECIALISTS

Medical History

Name: _____ **Account #:** _____ **Date:** _____

Date of birth and age: _____

Date last seen by your Physician for this condition? _____

Have you been treated this year by a physical or speech therapist? _____

Have you been treated this year by an acupuncturist or chiropractor? _____

Have you received Home Health treatment or services in the last 30 days? _____

Are you currently receiving other care for this condition? _____

At the present time, would you say that your health is: ___excellent ___very good ___fair ___poor?

Please mark the medical conditions that apply:

- | | | |
|--|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer-type _____ | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Broken Bones/Fracture | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Stroke | <input type="checkbox"/> Skin Disorders |
| <input type="checkbox"/> Circulatory / Vascular Problems | <input type="checkbox"/> Diabetes / High Blood Sugar | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Low Blood Sugar / Hypoglycemia | <input type="checkbox"/> Prostate Conditions |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Neurological Problems |
| | | <input type="checkbox"/> Depression |

Other (please describe): _____

Allergies (list): _____

Medications (list): _____

Recent Medical Testing: _____

Surgeries (include date): _____

Do you have metal/hardware in your body as a result of surgery? _____

Have you experienced any of the following symptoms during the last year?

- | | | |
|---|--|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Pain at Night | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Weight Loss or Gain |
| <input type="checkbox"/> Dizziness or Blackouts | <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Coordination Problems |
| <input type="checkbox"/> Joint Pain or Swelling | <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Weakness in Arms or Legs |



PELVIC & ORTHOPEDIC
PHYSICAL THERAPY SPECIALISTS

Patient Name _____ Acct.# _____ Date _____

PATIENT DOCUMENTATION OF CURRENT MEDICATIONS

Medicare requires all Medicare patients to document their current list of medications. This list must include ALL prescription medications that you are currently taking, over the counter medications and ALL herbal/vitamin/mineral/dietary/nutritional supplements. You MUST document the medication name, dosage, frequency and route of administration below. Please use more than one sheet if needed.

Medication OTC Supplement	Dosage	Frequency	Route of Administration (oral, topical, suppository, intravenous)

I _____, do hereby attest that this information is true, accurate
(Patient Name - Please Print) and complete to the best of my knowledge.

Patient / Guardian Signature

Date



PELVIC & ORTHOPEDIC
PHYSICAL THERAPY SPECIALISTS

Patient _____ Date _____

Check Your Risk for Falling

Please circle "Yes" or "No" for each statement below.			Why it matters
Yes (2)	No (0)	I have fallen in the past year.	People who have fallen once are likely to fall again.
Yes (2)	No (0)	I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall.
Yes (1)	No (0)	Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.
Yes (1)	No (0)	I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.
Yes (1)	No (0)	I am worried about falling.	People who are worried about falling are more likely to fall.
Yes (1)	No (0)	I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles, a major reason for falling.
Yes (1)	No (0)	I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.
Yes (1)	No (0)	I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.
Yes (1)	No (0)	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.
Yes (1)	No (0)	I take medicine that sometimes makes me feel light-headed or more tired than usual.	Side effects from medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls.
Total _____		Add up the number of points for each "yes" answer. If you scored 4 points or more, you may be at risk for falling. Discuss this brochure with your doctor.	

Reviewed by _____ Date _____



PATIENT CONSENT AND STATEMENT OF FINANCIAL RESPONSIBILITY

1. CONSENT FOR TREATMENT: I hereby consent to, and authorize my physical therapist, to provide care and treatment prescribed by my physician and/or considered necessary or advisable by my physician. I understand that a physical therapy diagnosis is not a medical diagnosis by a physician. I understand that my treatment may include techniques that can result in bruising, reddening of the skin and soreness after treatment, including, without limitation, myofascial release and soft tissue mobilization. I understand that my treatment may include, with my consent, examination of the pelvic floor performed either vaginally or rectally. I understand that it is my responsibility to inform my physical therapist if I experience any discomfort or pain during any treatment or if I have other unresolved concerns around my treatment. I understand that each patient's response to physical therapy intervention varies from patient to patient and it is possible that treatment may result in aggravation of existing symptoms or may cause inflammation of the condition for which I am seeking treatment.

2. APPOINTMENT ATTENDANCE AGREEMENT: I understand the importance of attending therapy consistently, scheduling appointments in advance and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand and acknowledge that appointment times given one week may not be available in subsequent weeks. ***I agree to provide notice to you at least 24 hours before if I need to cancel an appointment and I understand that cancellation of, or failing to keep an appointment with less than 24 hours prior notice will result in a cancellation fee of \$50.00. Cancellation fees cannot be billed to insurance and are my responsibility. I also agree that arriving more than 15 minutes late or departing more than 15 minutes early from an appointment will result in a \$25.00 fee that cannot be billed to insurance and is my responsibility.***

WORKER'S COMPENSATION PATIENTS (ATTENDANCE AGREEMENT): I understand that Pelvic & Orthopedic Physical Therapy Specialists ("POPTS) is required to inform my Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. I understand that any missed visits must be rescheduled per my authorized treatment plan and I must pay any cancellation fees.

3. RESPONSIBILITY FOR PAYMENT: All co-payments and self-pay services are due at the time of service. I acknowledge that in consideration of the services provided to me by POPTS, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide POPTS with my current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or health insurance benefits should be directed to my health insurance provider. I understand that my health insurance may pay for all or a portion of the services I receive from POPTS, but that I am responsible for any unpaid balance including, but not limited to, my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible. I understand that POPTS will bill my health insurance as a courtesy, but that I am responsible for any amounts not paid. I understand that auto insurance, worker's compensation and liability claims must be billed to a first-party carrier only. POPTS will not bill third-party carriers, will not file medical liens and will not wait for my bills to be paid after litigation is resolved. If formal collection procedures become necessary, I am responsible for any additional costs, including attorney's fees, incurred as a result of such collection procedures.

4. ASSIGNMENT OF BENEFITS: I hereby assign to POPTS all my rights and claims for reimbursement under my health insurance policy. I agree to cooperate with and to provide such information as is needed to establish my eligibility for such benefits.

5. ACCESS TO AND RELEASE OF HEALTH INFORMATION: I understand that POPTS may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I permit POPTS to provide information to any third party payer, insurance company, or agent which may be responsible in whole or part for paying my bill. I also permit the release of information to companies hired by these third parties to monitor utilization of rehabilitation services. I authorize my clinician(s) and POPTS's administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment.

_____(initials) I acknowledge that POPTS has made the *HIPAA Notice of Privacy Practices* available to me and that it outlines how my health information may be used and disclosed and how I may gain access to and control my health information.

_____(initials) I acknowledge that I understand the *Appointment Attendance Agreement* and will be By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

_____(initials) I acknowledge that I understand the COVID-19 Addendum which I have also signed and delivered to POPTS.

Printed Name of Patient

Signature of Patient or Legally Responsible Person

Date

Printed Name of above (if not the Patient)

Date

Pelvic & Orthopedic Physical Therapy Specialists complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender.



755 Ela Road, Lake Zurich, IL 60047
Ph 847.550.9784, Fax 847.550.9780
www.pelvicandorthopt.com



PATIENT CONSENT AND STATEMENT OF FINANCIAL RESPONSIBILITY

COVID-19 ADDENDUM

1. **Acknowledgment:** I acknowledge the current circumstances regarding the COVID-19 pandemic and desire to proceed with the care and treatment prescribed by my medical practitioner and/or considered necessary or advisable by my medical practitioner. I acknowledge that very little is known about the acute and long-term effects on COVID-19 on individuals; that over the course of time, there is a high risk I will at some point be exposed to COVID-19; that there is no way to predict my body's response to exposure and that this could range anywhere from no symptoms to severe illness, possibly including death. I will not visit the clinic if I am experiencing any symptoms of COVID-19 and I acknowledge that you may deny me entry into the clinic based upon my condition or other health factors. I acknowledge that it is a time of rapidly changing information and recommendations. I have been advised to review the most recent recommendations for the most up to date information. Recommended websites include: The United States Center for Disease Control (CDC), The World Health Organization (WHO).

2. **Multiple Treatments:** I am aware that my treatment may require multiple clinic visits. Although efforts will be made to hopefully lower my risk of COVID-19 exposure during these visits, there is no way to guarantee prevention of exposure. Current evidence supports transmission of the virus before and without any symptoms of infection. Undergoing treatments will inadvertently pose opportunity for exposure to COVID-19.

3. **Cancellations:** I acknowledge that during this time of rapidly changing information and evolving recommendations/restrictions, my treatment may be cancelled by you at any time.

4. **Indemnity:** I knowingly and freely choose to enter into treatments and release and hold harmless Pelvic & Orthopedic Physical Therapy Specialists, and its affiliates, partners, physicians, nurses, clinicians, support staff, and other members, formal or informal, of the team from all fault, coercion, negligence, liabilities, actions or inactions, which may cause harm whether minor or serious to me.

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

Printed Name of Patient

Signature of Patient or Legally Responsible Person

Date

Printed Name of above (if not the Patient)

Date



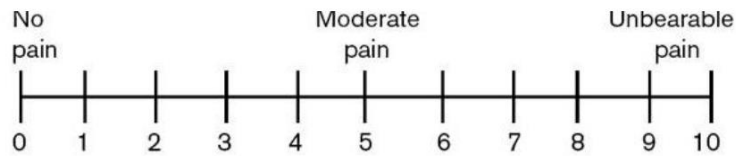
PELVIC & ORTHOPEDIC

PHYSICAL THERAPY SPECIALISTS

Patient Name _____ Acct# _____ Date _____

VISUAL PAIN SCALE

Please mark the number on the line that corresponds to your current level of pain



PAIN BODY MAP

Please indicate the location of any and all current pain and/or irritation on the body diagram

