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: _____

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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:

- ☐ Arthritis
- ☐ Broken Bones/Fracture
- ☐ Blood disorders
- ☐ Circulatory / Vascular Problems
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Cancer-type _____
- ☐ Lung Problems
- ☐ Stroke
- ☐ Diabetes / High Blood Sugar
- ☐ Low Blood Sugar / Hypoglycemia
- ☐ Kidney Problems
- ☐ Seizures
- ☐ Thyroid Problems
- ☐ Skin Disorders
- ☐ Head Injury
- ☐ Prostate Conditions
- ☐ Neurological Problems
- ☐ 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?

- ☐ Chest Pain
- ☐ Heart Palpitations
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Dizziness or Blackouts
- ☐ Joint Pain or Swelling
- ☐ Pain at Night
- ☐ Difficulty Sleeping
- ☐ Loss of Appetite
- ☐ Difficulty Swallowing
- ☐ Bowel Problems
- ☐ Urinary Problems
- ☐ Hearing Problems
- ☐ Vision Problems
- ☐ Headaches
- ☐ Weight Loss or Gain
- ☐ Coordination Problems
- ☐ Weakness in Arms or Legs

PELVIC & ORTHOPEDIC
PHYSICAL THERAPY SPECIALISTS

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.

PELVIC & ORTHOPEDIC
PHYSICAL THERAPY SPECIALISTS

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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

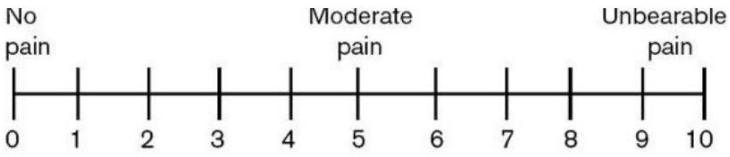
_____ _____
Printed Name of above (if not the Patient) Date

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