EMPOWER
PHYSICAL THERAPY

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PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, difficulty with bowel, bladder or sexual functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, or pelvic pain conditions.

I understand in order to evaluate my condition **it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination**. This examination is performed by observing and/or palpating the perineal region including the vagina, penis, and/or rectum. This evaluation will assess skin condition, reflexes, muscle length, tone, strength and endurance, scar mobility and function of the pelvic floor region.

Treatment may include, but is not limited to the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercise, soft tissue and/or joint mobilization and educational instruction.

Potential risks: I may experience an increase in my current level of discomfort or pain, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my therapist.
Potential benefits: Improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.
Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Release of medical records: I authorize the release of my medical records to my physicians/primary care provider or insurance company.

Videos / Pictures: For safety and security reasons: You may ask your therapist to take pictures and/or videos of you doing your exercises so you can reference at home. Any pictures or videos taken at Empower Physical Therapy are for educational purposes only and **CANNOT** be shared in any format (via email, phone, internet, social media…)

Cooperation with treatment: I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

No warranty: I understand that my physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss all treatment options with me before I consent to treatment.

I have informed my therapist of any condition that would limit my ability to have an evaluation and to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists. I have the right to receive the medical records generated by Empower Physical Therapy for a reasonable copy fee.

Patient Name: _____
(Please Print)

Patient/Guardian Signature: _____ **Date:** _____

Witness Signature: _____ Date: _____

470 John Young Way Suite 200 Exton, PA 19341 Phone: (610) 873-3076 Fax: (610) 873-3078

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Attendance Policy

(Please read thoroughly)

Empower Physical Therapy strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Failure to keep your scheduled appointments hinders our ability to provide the best care to our patients. **We expect 24 hours notice prior to re-scheduling or canceling an appointment.** This allows us the opportunity to offer that time slot to another patient (from the waiting list) and we can re-schedule your appointment so that you do not have to miss out on your visit(s). We must ask your full cooperation with the following attendance policy:

- If you are more than 15 minutes late for your appointment and fail to notify us, treatment will be cancelled and a fee charged for missing the appointment. Two (2) cancelled or no-show visits without 24 hours notice will result in all remaining appointments being removed from the schedule and discharge from physical therapy
- Failure to give Empower Physical Therapy the necessary 24 hours notice will result in a "No Show Appointment Fee"
- THE FEE CANNOT BE BILLED TO YOUR INSURANCE COMPANY AND WILL BE DIRECTLY YOUR RESPONSIBILITY

The Physical Therapy No Show Appointment Fee is as follows: $75 fee for the Initial Evaluation and $50 fee for all other appointments.

You will only be charged if you do not provide appropriate notice for your cancellation. All phone messages are received and recorded in a timely fashion. This policy applies to all patients, including worker's compensation.

Please Read The Following Information Carefully

By signing below, you understand Empower Physical Therapy will charge you **$50** for no-show appointments with less than 24 hours notice or cancellation.

We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and service to everyone.

All worker's compensation patients that are absent in the above descriptions will be noted to the Workers Compensation Insurance by phone contact and progress note.

Patient/Guardian Signature_____ **Date** _____ / _____ / _____

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PAYMENT AND COLLECTION POLICY

Empower Physical Therapy makes every effort to verify insurance coverage for physical therapy services. **Verifying coverage is no guarantee of payment.** We will submit the claims to your insurance company and attempt to secure payment. Ultimately, it is the **Clients Responsibility** to be aware of insurance coverage. Empower Physical Therapy has the right to collect co-pays, co-insurance and/or deductible amounts at the time of your visit. If we are billing your auto insurance carrier, we will need your health insurance information as a backup.

I certify that I am covered by _____ Insurance Company and I assign directly to Empower Physical Therapy all insurance or workman's compensation benefits otherwise payable to me. I hereby authorize Empower Physical Therapy to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I understand that I am responsible for any balance **not covered** by my insurance per usual and customary rate.

Payment is expected at the time of service. Unpaid balances left by your insurance companies will be your responsibility. In the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements. Cash, money order, and/or HSA, HRA, MasterCard, Visa, American Express and Discover are accepted forms of payment on the account.

Please be advised that Empower Physical Therapy is not a credit grantor and therefore, failure to maintain payment arrangements may result in the placement of your account with a collection agency or attorney for collection.

Collection Policy: **In the event that you fail to pay as agreed or as the terms state, you agree to pay any and all collection fees, attorney fees, court cost or recovery costs. Please avoid this by keeping up with your payments and communication with the office staff.

- ☐ **HEALTH INSURANCE:** Primary insurance will be billed by Empower Physical Therapy as a courtesy to you. Patients are responsible for knowing their own insurance benefits for physical therapy. Payment of insurance benefits is not forthcoming on chargers older than 60 days; therefore outstanding charges regardless of insurance carrier will be due by the patient above and beyond co-pay, co-insurance, deductible, and/or primary coverage classified as "above usual and customary" upon receipt of the Explanation of Benefits.

- ☐ **MEDICARE:** Medicare will pay 80% of Medicare approved charges; therefore 20% will be collected as a co-insurance. Please check your Medicare Handbook for details about capitation and run-out benefits.

- ☐ **WORKERS COMPENSATION AND MOTOR VEHICLE ACCIDENTS:** Patients will be asked to provide the following information: Date of Injury, Claim Number, Billing Address, Medical Payment Coverage and any authorizations required for services to be rendered. We will obtain a copy of your health insurance card for submission of any balance not covered. The patient is responsible for any balance not covered.

- ☐ **SELF PAY:** Self pay patients are required to pay each visit. We can provide a financial summary so patients can submit towards their out-of-network insurance benefits.

Patient Name: _____
(Please Print)

Patient/Guardian Signature: _____ **Date:** _____

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NOTICE OF PRIVACY PRACTICES

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you as a patient may be used and disclosed and how you can get access to your individually identifiable health information. Please review this notice carefully.

Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your personal health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. You may request a copy of our most current Notice at any time. You may at any time access, copy, and amend your records, request confidential communications, obtain accounting of disclosures that require authorization, and place restrictions on the use of your PHI.

We may use and disclose your PHI in the following ways:

- TREATMENT: PHI may be disclosed to healthcare providers or others assisting in your care.
- PAYMENT: Our practice may use and disclose your PHI in order to bill and collect payment for the services rendered. For example, we may contact your health insurer to certify that you are eligible for benefits, and we may provide your insurer with details regarding your treatment to determine if your insurer will pay for treatment. PHI may also be sent to attorneys in lien or third party actions for payment.
- HEALTHCARE OPERATIONS: Our practice may use and disclose your PHI to operate our business including but not limited to the evaluation and review of the quality of care you received from us by our physical therapy provider network, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations. Finally, our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

All other disclosures of your personal health information will be made only with your written authorization and you may revoke that authorization at any time.

If you have questions about this Notice, please contact Rachel Miller PT, MS, WCS, CFMT, Owner, Empower Physical Therapy, Inc.
Effective 09/20/2016

Patient Name: _____ (Please Print)

Patient/Guardian Signature: _____ **Date:** _____

I have been made aware and understand this Notice

Witness Signature: _____ Date: _____

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PELVIC FLOOR PATIENT HISTORY

Name: _____ **Age**: _____ **Sex Assigned at Birth:** _____

Gender Identification: _____ **Preferred Pronouns:** _____

Height: ____ feet ____inches **Weight:** _____lbs

Date of Onset: _____ **Occupation**: _____

Describe the current problem: _____

What is your goal for PT? _____

If pain is present, rate pain on a 0-10 scale with 10 being the worst: _____

Describe the pain (ex: constant, comes and goes, etc.):_____

Is the pain staying the same, getting worse or getting better? _____

Painful intercourse? Y/N

Describe previous treatment or exercises: _____

When do you lose urine? _____

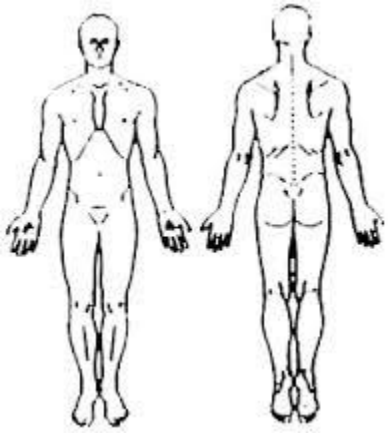
How many times a day to you urinate? _____ Urge sensation Y/N

How many pads do you use per day?_____

How often do you have a bowel movement? _____

What relieves your symptoms? _____

Please mark (X) of pain location(s) below



What activities aggravate your symptoms? Check/circle all that apply:

___ Sitting greater than _____ minutes
___ Standing greater than _____ minutes
___ Walking greater than _____ minutes
___ Changing positions (sit to stand)
___ Light Housework
___ Sleeping
___ Vigorous exercise
___With Cough/Sneeze/Straining
___With Lifting/Bending
___With Cold Weather
___With anxiety
___Sexual Activity
___No activity affects the problem
___Other_____

Since the onset of your current symptoms have you had?

Y/N Fever Chills **Y/N** Unexplained Tiredness **Y/N** Unexplained weight change **Y/N** Night Pain/Sweats
Y/N Unexplained Muscle Weakness **Y/N** Dizziness/Fainting **Y/N** Change in bladder or bowel functions
Y/N Numbness/Tingling **Current Level of Stress: High ___ Medium ___ Low ___**

Have you ever had any of the following conditions or diagnosis? Circle all that apply/describe:

Abuse	Hepatitis	Pacemaker
Adhesive Tape Allergies	High Blood Pressure	Pelvic Pain
Anemia	HIV/AIDS	Prostate Enlargement
Anxiety	Incontinence (Urinary/bowel)	Raynaud's (cold hands & feet)
Arthritic Condition	Infections	Rheumatoid Arthritis
Asthma	Painful intercourse	Sacroiliac/Tailbone Pain
Cancer	Interstitial cystitis (IC)	Scoliosis
Childhood Bladder Problems	Irritable Bowel Syndrome	Seizures
Chronic Fatigue	Irregular Vaginal Bleeding	Spinal Cord Injury
Depression	Do you have an IUD?	STD's/Abnormal PAP
Diabetes	Joint Replacement	Stress Fractures
Eating Disorders	Kidney Disease	Stroke
Emphysema	Latex Sensitivity	Thyroid: Hypo
Fibromyalgia	Low Back Pain	Thyroid: Hyper
Head Injury	Lyme Disease	TMJ/Neck Pain
Headaches	Lack of Menstruation	Urinary Tract Infection
Hearing Loss	Multiple Sclerosis (MS)	Vision Problems
Heart Problems	Osteoporosis	Other
# of Pregnancies _____	# of Deliveries_____	

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Patient Contact/Emergency/Medication/Surgery Information

NAME: _____

I give my permission for messages to be left at the phone number (s) & email below:

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Email: _____

Emergency Contact & who we may speak with regarding your case:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Please give the following medications that you are currently taking (Prescription·over the counter·herbals·vitamins·mineral/dietary/birth control):

Name of Drug	Dosage	Frequency	How Taken

Please list any operations (with date) that you have received in your lifetime:

Operations	Date	Operations	Date

X-rays / MRI's	Date	X-rays / MRI's	Date