PATIENT REGISTRATION FORM

Today's Date _____

Referring Doctor/How did you hear about us? _____

Last Name: _____ First Name: _____ M.I.: _____

Home Address _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Phone Information: Home _____ Cell _____

E-mail Address: _____

Would you like to receive our free monthly e-mail newsletter? Yes _____ No _____

Date of Birth: _____ Last 4 of SS Number: _____ Gender: M _____ F _____

Marital Status: M _____ S_____ D_____ W_____ Spouse's Name: _____

Employer: _____ Occupation: _____

Work Phone Number: _____ Ext: _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone Number: _____

Is this injury related to:

Work? Yes ____ No ____ Auto Accident? Yes ____ No ____ Other Accident? Yes____ No____

Date of Injury: _____ Is there an attorney involved? Yes_____ No_____

Momentum Physical Therapy, P.C.

Pelvic Floor Therapy Intake Sheet

For what condition are you seeking treatment?

□ Urinary Incontinence (Leaking of Urine) □ Urgency (Urinary/Fecal)

□ Bowel Incontinence (Leaking of Feces) □ Pelvic Pain

□ Pelvic Prolapse (Bulge or Protrusion in Vagina) □ Other (Specify): _____

What have you done in the past to improve your symptoms? _____

Have you ever been to physical therapy for this or any other condition? _____

Is there anything that makes your condition worse/better? _____

What are your goals for therapy? _____

For female patients, please answer the following:

Menstruation: (If applicable) When was your last period? _____

Currently Pregnant? □Yes □No □Possibly

Birth: # of Pregnancies _____ # of Vaginal Deliveries _____ # of C-Sections _____

Birth Weight of Children: _____, _____, _____, _____. Did you have trouble healing? _____

Did you have bowel or urinary incontinence following pregnancy? _____

Medical History: Please list any major surgeries including hip, back, pelvic or abdominal surgeries and year:

_____

_____

Residual pain, complications, or co-morbidities following surgery? _____

Do you have any have any surgical scars? Where? _____

List Medications: _____

Do you have any drug or other allergies? _____

How would you rate your stress level? 0 (no stress) to 10 (extremely stressful) _____

Have you ever been to counseling/psychology services? _____

Pain - Do you have pain with:

Sexual Intercourse?	□Yes □No	Pain with sitting?	□Yes □No
Pelvic Exam?	□Yes □No	Tight Clothing?	□Yes □No
Tampon Use?	□Yes □No	Biking?	□Yes □No

Urination/Bowel Movements? □Yes □No

Pain Rated 0 (no pain) to 10 (excruciating pain) _____

Do you/have you had frequent urinary tract infections? □Yes □No Do you have back pain? □Yes □No

Leg Pain? □Yes □No Groin Pain? □Yes □No Abdominal Pain? □Yes □No

Activity:
What is your occupation? If retired or a student what activities occupy your time? _____
What do you do for physical exercise? _____
How many hours in a day do you: Sit _____ Stand _____ Lift _____ Push/Pull _____

Your Bladder Symptoms:

Do you lose urine when you cough/sneeze/laugh?	□Yes □No □Sometimes
Do you strain to empty your bladder?	□Yes □No □Sometimes
Do you lose urine when you hear water running?	□Yes □No □Sometimes
Do you have a falling out feeling?	□Yes □No □Sometimes
Do you lose urine on the way to the bathroom?	□Yes □No □Sometimes
Do you have blood in your urine?	□Yes □No □Sometimes
Do you wet the bed?	□Yes □No □Sometimes
Do you have pain with a full bladder?	□Yes □No □Sometimes
Do you lose urine with sit to stand or lifting?	□Yes □No □Sometimes
Do you leak with exercise/dance/jumping?	□Yes □No □Sometimes
Do you have difficulty starting a stream of urine?	□Yes □No □Sometimes
Do you have a sudden, strong urge to urinate?	□Yes □No □Sometimes
Do you feel you fully empty your bladder?	□Yes □No □Sometimes

Now many times do you urinate in a day? (i.e. every 30 minutes, every hour, etc.) _____
How long can you delay the urge to urinate? _____ mins/hours
How many times do you wake at night ***because of*** the urge to urinate? _____
Do you use pads? □Yes □No □Sometimes What kind? _____ How many pads in a day?_____
If you leak, now many times does it occur? (i.e. 1/day, 1-2/week, 3-4/month, etc) _____

Bowel Symptoms:

Do you strain to have a bowel movement?	□Yes □No □Sometimes
Leak/stain feces or gas?	□Yes □No □Sometimes
Take laxatives/enema with bowel movement?	□Yes □No □Sometimes
Have diarrhea often?	□Yes □No □Sometimes
Include fiber in your diet?	□Yes □No □Sometimes
Take supplemental fiber?	□Yes □No □Sometimes
Have a very strong urge to move bowels?	□Yes □No □Sometimes

How often do you move your bowls? _____ Per day/week
Most common stool consistency? Liquid_____ Soft _____ Firm_____ Pellets _____ Other_____

Fluid Intake: (One glass is 8oz or one cup)
Cups of water _____ Cups of caffeinated drinks_____ Cups of non-caffeinated drinks_____

Your Sexuality:
If you are not sexually active, please pick one of the following
□ No Interest □ No Partner □ Partner Not Able □ Other _____
Are you incontinent of urine with sexual activity? □Yes □No □Sometimes
Have you ever been raped or forced to engage in sexual activity against your will? □Yes □No

Learning Style Preference:
□ None □Pictures or Videos □Reading □Discussion

Special Interventions:
Patient needs □None □Large Print □Caregiver Instructed □Interpreter
□Other _____

Are there special religious or cultural practices that may affect/guide your treatment? □Yes □No
Specify: _____

PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

Informed Consent for Treatment:

The term "informed consent" means that the potential risks, benefits and alternatives of therapy evaluation and treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information that the initial visit concerning the evaluation, treatment and options available for my condition.

I also 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 that 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 and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length and endurance, scar mobility and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle feedback.

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

Potential Risks: I may experience an increase in my current level of pain or discomfort, 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 may include an improvement in my symptoms and increase in my ability to perform my daily activities. I may experience increase 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.

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 the physical therapist cannot make any promises or guarantees regarding a cure 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 or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists and therapy assistants and technicians of MOMENTUM PHYSICAL THERAPY, P.C.

Date _____ Patient Name (Printed) _____

Patient Signature _____

*Parent or Guardian Signature if patient is under 18

Momentum Physical Therapy, PC
1939 Wilmington Dr. Unit 101
Fort Collins, CO 80528
970.377.1422

PLEASE SIGN APPLICAPLE AREAS

1. **IF PATIENT IS UNDER 18**: I give permission for the child in my care to be treated by Momentum Physical Therapy, PC.

   Responsible Party Signature _____ Date _____

2. **INSURANCE ASSIGNMENT AND RELEASE**: I, the undersigned, certify that I (or my depended) directly assign insurance benefits, if any, otherwise payable to me for the services rendered to Momentum Physical Therapy, PC. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

   Responsible Party Signature _____ Date _____

3. **MEDICARE AUTHORIZATION**: I request that payment of the authorized benefits be made to either me or on my behalf to Momentum Physical Therapy, PC any serviced furnished me by the office. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services. I understand that I am responsible for the deductible, co-insurance and any non-covered service.

   Responsible Party Signature _____ Date _____

progressive joint spine & sport rehabilitation
Momentum physical therapy, p.c.

Momentum Physical Therapy, PC

Office Policy

We hope you understand that credit and collection policies are a necessary part of assuring the financial resources needed to maintain this office for our patients and the community. Charges for services rendered at our office are due and payable at the time of service. We accept case, check and credit card. If you have any questions regarding our charges, please ask.

If you have health insurance, please understand that this is an agreement between you and your insurance company to reimburse certain amounts of care. Our bill for physical therapy services is an agreement between you and our office. You are responsible for the payment of your bill with us, regardless of the status of your insurance claim, unless you are with an HMO, PPO or a similar type of plan in which we participated.

If you have health insurance with which we participate, we will bill your insurance claim for you. We do expect any required deductible, co-insurance and copayment at the time of service. If we do not participate with your insurance company, payment is expected at the time of the service, and we will file your claim as a courtesy for you.

If unusual circumstances should make it impossible to meet our credit terms, please call or personally discuss the matter with us. This will avoid misunderstandings and enable you to keep your account in good standings. Accounts 90 days past due are referred to a collection agency, unless prior arrangements have been made. On any account that is sent to a collection agency, the patient is responsible for any collection fees, interest and court fees that may occur.

MISSED APPOINTMENTS

To keep appointments on time, it has become necessary for us to charge for missed appointments. If you cannot keep an appointment, please call to cancel. You will not be charges for cancelling your appointment. If you fail to call, the following policy applies:

1. First missed appointment: the patient will be contacted by telephone about the missed appointment and will be reminded about the cancellation policy. We will be happy to reschedule the appointment to the next available opening.
2. Second missed appointment: A fee of $30.00 will be charged, which is not covered by insurance. Payment of this charge is required within 30 days.
3. Third missed appointment: The full price for the scheduled appointment will be charged. This charge is not covered by insurance. Payment is required within 30 days.
4. Fourth missed appointment: Because repeat offenders have prevented other patients from being seen, the patients care will be reviewed for possible termination.

Signature _____ Date _____

Patient Name _____ Relationship _____

progressive joint spine & sport rehabilitation
Momentum physical therapy, p.c.

Standards for Privacy of Individually Identifiable Health Information

("THE PRIVACY RULE")

The Privacy Rule created by the Department of Health and Human Services sets national standards to protect your personal health information and gives you increased access to your medical records.

At Momentum Physical Therapy, P.C., we are committed to safeguarding your privacy. While the information we collect about you is critical to providing superior service and care, be assured that we are dedicated to maintaining the confidentiality of the personal information we have. To help you understand how we protect your personal information, this notice describes our current privacy policy and practices.

Confidentiality and Security of Medical Information
We understand that you may be especially concerned about the privacy of your medical information. Momentum Physical Therapy, P.C. practices and follows the required steps, as set by The Privacy Rule, to protect and secure your records containing your individually identifiable health information. Access to your information by employees and other representatives is restricted to those individuals having a direct need for such information.

Information we may collect and use
Under the Privacy Rule, the information we obtain from you can be used to correspond with physicians, nurses, and/or physician assistants, to insurance companies for billing purposes and to case managers/adjustors only if they are involved directly with your care. Information is gathered and/or processed in writing, verbally, by fax, electronically, by telephone and from physical examination.

Information we may disclose
We regard all your personal information as confidential. However, in the course of treating you there are circumstances in which we may disclose to others information we have about you, but only if they are directly involved with your case. Information can be given to doctors, nurses, physician assistants, insurance companies, case managers and claim adjustors.

By signing below I acknowledge I have read and received a copy of Momentum Physical Therapy's practices and policies regarding protection of my personal health information.

Patient's Signature: _____ Date: _____
*Parent Signature if patient is under 18

*I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, my co-insurance and/or co-payment, and any charges not reimbursed by my insurance carrier
*I authorize payment of medical benefits directly to Momentum Physical Therapy, P.C.
*I understand that if I have Medicare and do not have a secondary insurance and am responsible for the 20% "patient responsibility" per Medicare Guidelines
*I understand that I am responsible for knowing and meeting the requirements of my insurance plans
*I agree to pay my co-payments and/or co-insurance at the time of service

MOMENTUM PHYSICAL THERAPY, P.C.

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY

MOMENTUM PHYSICAL THERAPY, P.C.'s LEGAL DUTY

MOMENTUM PHYSICAL THERAPY, P.C. is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein

USES AND DISCLOSURE OF HEALTH INFORMATION

MOMENTUM PHYSICAL THERAPY, P.C. uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care we provide. For example, MOMENTUM PHYSICAL THERAPY, P.C. may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

MOMENTUM PHYSICAL THERAPY, P.C. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, MOMENTUM PHYSICAL THERAPY, P.C.'s policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment or administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. MOMENTUM PHYSICAL THERAPY, P.C. will consider all such requests on a case by case basis, but the practice is not legally required to accept them

CONCERNS AND COMPLAINTS

If you are concerned that MOMENTUM PHYSICAL THERAPY, P.C. may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on MOMENTUM PHYSICAL THERAPY P.C.'s health information practices, or if you have a complaint, please contact the following person

MOMENTUM PHYSICAL THERAPY, P.C.
Michael J. Ressler M.S., MPT, CSCS
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