Orthopedic Rehabilitation Specialists
8720 N. Kendall Drive, Suite 206
Kendall, Florida 33176
Phone: (305) 595-9425

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 at 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, low back pain, myofascial pain or pelvic pain conditions. Restrictions in this area may also be contributing to symptoms in other areas.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapists 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, strength and endurance, scar mobility and function of the pelvic floor region. I will have the opportunity to give/revoke my consent at any time at each treatment session.

Treatment may include, but is not limited to the following: observation, palpation, pressure and/or distraction to the coccyx bone, 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 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.

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.

Cancellation Policy: I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of $20.00.

No warranty: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for improvement in my condition. I understand my therapist will share with me his/her opinions regarding potential results of physical therapy 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 be treated. I hereby request and consent to the evaluation and treatment to be provided.

_____

Patient Name (please print)

_____ Date _____

Patient Signature

_____ Date_____

Witness Signature

***If you are pregnant, have an infection of any kind, have vaginal dryness, are less than 6 weeks postpartum or post-surgery, have severe pelvic pain, sensitivity to lubricant, vaginal creams or latex, please inform the therapist prior to the pelvic floor assessment.

Pelvic Floor/Urinary Incontinence Functional Scale

PFIQ – 7 Instructions: Some women find that bladder, bowel, or vaginal symptoms affect their activities, relationships, and feelings. For each question place an **X** in the response that best describes how much your activities, relationships, or feelings have been affected by your bladder, bowel, or vaginal symptoms or conditions **over the last 3 months**. Please make sure you mark an answer in all 3 columns for each question.

How do symptoms or conditions relating to the following → → → Usually affect your …↓	*Bladder or urine*	*Bowel or rectum*	*Vagina or pelvis*
1. Ability to do household chores (cooking, housecleaning, laundry)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
2. Ability to do physical activities such as walking, swimming, or other exercise?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
3. Entertainment activities such as going to a movie or concert?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
5. Participating in social activities outside your home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
6. Emotional health (nervousness, depression, etc.)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
7. Feeling frustrated?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

All of the items use the following response scale:
0 = not at all; 1 = somewhat, 2 = moderately, 3 = quite a bit

Pelvic Floor/Urinary Incontinence Functional Scale (% of impairment)

☐ 21 - 100% impairmen
☐16-20 80 – 99%
☐12-16 60 – 79%
☐9-12 40 - 59%
☐5-8 20 – 39%
☐1-4 1 – 19%
☐0 0%

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Have you had any type of therapy (OT, PT, Speech or Chiropratic) during 20__ *other than* in our office.

☐ **YES *if so*:**

When_____

Where_____

How Many Visits_____

☐ **NO**

Patient Name:_____

Date:_____

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NAME: _____ **TODAY'S DATE:** _____

DATE OF BIRTH: ____/____/____ HEIGHT _____ WEIGHT _____ **L** – HANDED – **R**

Marital Status: _____ # Children _____ Ages _____ Currently Working Y N

Occupation _____ Referring MD _____

Is your present problem related to: Illness _____ Accident _____ Work-Related _____

Please indicate for which body region(s) are you seeking treatment: (Please Circle)

Neck *Mid Back* *Low Back* *Shoulder* *Elbow* *Hand* *Wrist* *Hip*
Knee *Ankle/foot* *Other*_____

When did your symptoms start? _____

Can you identify a cause for your symptoms? Y N

If yes, specify _____

Have you ever had similar symptoms in the past? Y N
If yes, when? _____

Have you recently had the following tests? (Circle all that apply):

X-Rays *CT Scan* MRI *Bone Scan* Blood Tests *EKG* Echocardiogram

Stress Test *EMG* Pulmonary Function Test *Myelogram*

Pain rating: Indicate your average level of pain by CIRCLING the appropriate number on the scale below:

0 1 2 3 4 5 6 7 8 9 10

Pain Free **Most Severe**

Have you seen anyone else for this problem? (Circle all that apply)

Physician *Physical Therapist* Chiropractor *Osteopath* Podiatrist

Dentist Psychologist/Psychiatrist *Other*

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NAME: _____

The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapist will answer any questions during your exam. This form is considered part of your medical record.

Describe the character of your **pain**: (Does it feel... sharp, dull, achy, etc.?) _____
Is your pain worse in the **am** _____ **pm** _____?
Is the pain there all the time? **Y** **N**
Do you have numbness, tingling, or weakness? **Y** **N** Location? _____
Have you had any recent changes in your bowel, bladder or sexual function? **Y** **N**
What activities/positions make your pain **worse**? _____
What activities/positions make your pain **better**? _____

HAVE YOU:		IF YES, EXPLAIN:
Experienced any trauma (i.e. motor vehicle accident or fall from a height?	YES NO	_____
Experienced any head trauma / brain injury?	YES NO	_____
Experienced an inability to focus or concentrate recently?	YES NO	_____
Experienced unusual clumsiness or lack of coordination?	YES NO	_____
Had open wounds / redness / cuts / infection recently?	YES NO	_____
Experienced unexplained back or flank pain?	YES NO	_____
Experienced groin/hip/thigh aching or pain that increases with activity?	YES NO	_____
Sustained a blow or trauma to any body part?	YES NO	_____
Recently begun an exercise program or modified an existing program?	YES NO	_____
Taken a long car ride / bus trip /plane ride?	YES NO	_____

PLEASE PROVIDE A LIST OF MEDICATIONS YOU ARE CURRENTLY TAKING:

Medication	Dosage	Frequency	How Taken (oral, injection, etc.)

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NAME_____

Have you ever suffered from or been told that you have:	YES	NO	Therapist Comments:
High blood pressure			
Thyroid problems			
Diabetes (high blood sugar)			
Osteoporosis			
Circulation or vascular problems			
Seizures / Epilepsy			
Recent / Repeated Infections			
Arthritis / Rheumatoid Arthritis / Gout			
Kidney problems			
Cancer			
Head injury / Headaches			
Heart problems / Pacemaker			
Lung / Respiratory problems / Asthma			
Multiple Sclerosis / Parkinson's Disease			
Stroke / Neurological problems			
Liver Problems / Hepatitis			
Blood disorders / Blood Clots			
Low blood sugar			
Tuberculosis			
Broken bones (fractures)			
Ulcers / stomach problems			
Allergies			
FOR WOMEN ONLY:			
Pelvic inflammatory disease			
Endometriosis			
Any complicated pregnancies or deliveries			
Trouble with your period			
Are you or could you be pregnant?			
FOR MEN ONLY:			
Prostate Disease			
HAVE YOU RECENTLY HAD:			
Unexplained Weight Loss/ Gain			
Fatigue / Tiredness / Malaise			
Diarrhea / Constipation / Incontinence			
Frequent Urination			
Blood in Stool or Urine			
Unexplained fever or chills / sweating			
Shortness of breath / Difficulty Breathing			
Cough / Hoarseness			

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HAVE YOU RECENTLY HAD:	YES	NO	Therapist Comments:
Unexplained fever or chills			
Visual problems / Loss of Vision			
Joint Pain and/or Swelling			
Difficulty Walking			
Nausea / Vomiting			
Numbness or tingling			
Weakness in your arms or legs			
Difficulty swallowing			
Pain at rest			
Pain at night			
New Onset of Headaches			
Hearing Problems			
Loss of appetite			
Chest Pain			
Heart palpitations / Heart Racing			
Dizziness or Loss of Consciousness			
Loss of balance / Any Recent Falls			
Implants / Metal Implants			
Difficulty Sleeping			
DO YOU:			
Smoke?			
If yes, how much? (packs per day)			
Have any significant family history of illness/ disease?			
Have any other medical problems?			

HAVE YOU:			
Had surgery or been hospitalized in the past?	YES	NO	If yes, please explain below
A.	REASON:		DATE:
B.	REASON:		DATE:
C.	REASON:		DATE:
Who is your primary doctor, or the doctor you see most often?			
When was your last general check-up?			DATE:

Please describe your job/social activities and your current ability to perform them:

_____

What do you want to accomplish from your course of Physical Therapy Treatment?

_____

Is there anything else you feel is important to tell me?

_____

Name: _____ **Signature:** _____

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Date _____

Patient Name _____ Date of Birth _____

Address _____ Zipcode _____

Home Phone # _____ Cell Phone # _____ Marital Status _____

S.S.# _____-_____-_____ Driver's License # _____

E-mail Address _____ Referred by: _____

Employer _____ Office Phone# _____

Employer Address _____ Occupation _____

Spouse/Responsible Party _____ Phone # _____

Employer _____ Occupation _____

Primary Insurance _____ ID# _____ Grp# _____

Secondary Insurance _____ ID# _____ Grp# _____

Is this a worker's compensation injury? **YES/ NO** *If yes*, date of injury _____

Employer at time of injury _____ Phone # _____

Worker's comp. Insurance Carrier _____ Claim # _____

Is this an auto accident? **YES/ NO** *If yes*, date of accident _____

Insured's name _____ Policy # _____

Auto Insurance Carrier _____ Phone # _____

Is this a liability or legal case? **YES/ NO** *If yes*, please provide attorney information: _____

Emergency Contact _____ Phone # _____

Relationship _____ Address _____

The following persons are allowed to receive and/or review all my medical records, reports and appointments associated with my treatment. Those who *I authorize* are:

1. _____ 2. _____ 3. _____

I authorize any insurance carrier, employer, hospital or physician to release any information requested with regard to my current physical condition. This authorization shall remain in effect until my course of treatment is completed or it is revoked by me in writing. A photocopy of this is to be considered as valid as the original.

PATIENT SIGNATURE / RESPONSIBLE PARTY

Patient/ Guardian Signature: _____ Relationship to Patient _____

Print Patient Name: _____ Date: _____

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FINANCIAL AGREEMENT

I hereby assign all medical benefits, including major medical benefits, to which I am entitled including Medicare, private insurance and any other health plans or insurance coverage to Orthopedic Rehabilitation Specialists, Inc., including any settlements from lawsuit. Please remember that verification of insurance benefits is not a guarantee of payment. I am responsible for the remaining balance, including deductibles, and non-covered expenses. If for any reason the account is assigned to an attorney for collections and/or lawsuit, Orthopedic Rehabilitation Specialists Inc. will be entitled to reasonable attorney's fees and cost of collections. To the extent necessary to determine liability of our payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical/financial record. I understand that I am financially responsible for all charges whether or not they are paid by said insurance. I authorize Orthopedic Rehabilitation Specialists Inc. to release all information necessary to secure payment.

CANCELLATION POLICY

I understand that it is my responsibility to keep scheduled appointments. **Failure to cancel with 24 hours notice will result in a $40.00 administration fee.** Failure to notify our office may result in a full day visit charge.

CONSENT, USE, DISCLOSURE AND ACKNOWLEDGEMENT OF HEALTHCARE AND PRIVACY PRACTICES

I have had full opportunity to read and consider the contents of the Consent form and the posted Notice of Privacy Practices. Understand that by signing this form I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

INFORMED CONSENT FOR PHYSICAL THERAPY

Physical therapy involves the use of many different types of physical evaluation and treatment. At Orthopedic Rehabilitation Specialists, we use a variety of procedures and modalities to help us to try to improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

The physical responses to a specific treatment can vary widely from person to person. It is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee that our treatment will help the condition for which you are seeking treatment. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis(es), symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risk(s) associated with your exercise(s), your therapist will be glad to answer them.

I acknowledge and understand the statement above. I understand that my treatment program will be explained to me by Orthopedic Rehabilitation Specialists, and that I am able to ask any question or state any concerns. I understand the risks associated with a program of Physical Therapy as outlined to me, and I authorize treatment.

Patient Name (Printed):_____ Date:_____

Patient Signature:_____ Guardian (if under 18)_____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/19

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED X DATE X

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED X

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.