PLYMOUTH
PHYSICAL THERAPY SPECIALISTS

ORTHOPEDICS | SPORTS MEDICINE | INDUSTRIAL REHABILITATION

THE LEADERS IN SPORTS MEDICINE FOR OVER 25 YEARS

Providing Sports Medicine Care to Professional, Collegiate and High School Athletes for over 25 years

Welcome to Plymouth Physical Therapy Specialists! Meeting and exceeding your goals for recovery is our primary objective. We dedicate an abundance of resources to prepare our clinicians and support staff to be able to provide specialized treatment for you. Our goal is to deliver expert level orthopedic treatment and advice in a friendly and supportive environment. We feel that optimal rehabilitation of any injury is dependent on the efforts of you the patient and your clinician. We will communicate with your physician throughout the duration of your care and if you are using insurance to cover the cost of treatment will make every effort to help you understand the coverage provided to you.

It is important that you understand the nature of your injury as well as the plan for your recovery. The therapist will guide you through this process. Some of the things that are important for a successful outcome are as follows:

1. Maintain open communication with your therapist about your injury and any changes in your status.
2. Attend all scheduled appointments at the frequency and duration recommended by your therapist. *We understand that circumstances arise that prevent you from keeping some appointments. In these cases we will make an effort to reschedule the appointment within the same week.*
3. Complete all home exercises as prescribed by the therapist. Also follow any restrictions/precautions advised to you by your therapist or physician.
4. Communicate any questions about your insurance including copay or deductible responsibility to our front office staff. They will be happy to help you.
5. Always check out with the front desk at the end of each appointment.

We look forward to working with you and are grateful that you have chosen Plymouth Physical Therapy Specialists! As a private medical practice we depend on the success of our treatments and satisfaction of our patients. Please tell your friends and family about us if they are in need of physical therapy.

In health and wellness,
Plymouth Physical Therapy Specialists

You have been scheduled to see _____.

You can contact us at _____if you have questions or need to reschedule an appointment.

STATEMENT OF PATIENT RIGHTS

* The right to efficient & equal service regardless of race, sex, physical or mental handicap, religion, ethnic background, education, social class or economic status.

* The right of considerate, courteous & respectful care from all our staff.

* The right of complete information in terms the average patient can reasonably be expected to understand.

* The right to informed consent and full discussion of risks and benefits prior to any invasive procedure, except in an emergency. The right to discuss alternatives to proposed procedures.

* The right to obtain assistance in language interpretation.

* The right to know the names, titles, and professions of the staff to whom you speak and from whom you receive services or information.

* The right to refuse examination, discussion and procedures to the extent permitted by law, and to be informed of the health and legal consequences of this refusal.

* The right of access to your personal health records.

* The right of respect for your privacy.

* The right of confidentiality of your personal health records as provided by law.

* The right to expect reasonable continuity of care within the scope of services and staffing of the facility.

* The right to respect for your rights and religious options.

* The right to present complaints to the Director of our facility without fear of reprisal.

Notice of Privacy Practices

(Effective September 23, 2013)

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

Understanding Your Health Record

A record is made each time you are treated at our Clinic. Your injuries, evaluation and test results, diagnosis, treatment, and a plan of care are recorded. This information is most often referred to as your "health or medical record," and serves as a basis for planning your care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure its accuracy and enable you to relate to who, what, when, where, and why others may be allowed access to your health information. This Clinic uses health information about you for treatment, to obtain payment for treatment, and to evaluate the quality of care you receive, and as well as for other administrative and operational purposes. Your health information is contained in a medical record that is the physical property of our Clinic.

Our Responsibilities

This Clinic is required by law to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This Clinic is required to abide by the terms of this notice, as currently in effect, and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations. This Clinic reserves the right to change its practices and effect the new provisions with respect to all health information that it maintains (including such information that this Clinic had prior to implementation of the new provision). Other than for reasons described in this notice, this Clinic agrees not to use or disclose your health information without your authorization.

Use or Disclosure of Your Health Information <u>Without</u> Your Authorization

This Clinic may use and disclose your health information in order to provide "Treatment", obtain "Payment" and perform our "Health Care Operations", as well as other specific reasons as detailed below:

• **Treatment** – We may use and disclose health information about you to provide you with products and services or related medical treatment or services. To this end, we may communicate with other health care providers regarding your treatment and coordinate and manage your health care with others. For example, information related to your treatment may be shared with a health care provider, such as your physician, a pharmacist, nurse, or other person providing health services to you. This information is necessary for health care providers to determine what treatment you should receive. Health care providers also may record actions taken by them in the course of your treatment and note how you responded to the actions.

• **Payment** – We may use and disclose health information about you to others for purposes of receiving payment for treatment and services that you receive. For example, information regarding treatment you have received may be sent to you or someone who pays on your behalf (such as a family member or a credit card company) in order for this Clinic to receive payment. The information used in this fashion may include details regarding your services that identify you and could identify your diagnosis or treatment. Although it is unlikely, if other treatment providers need medical information about your treatment in order to bill for their services, we may provide it to them.

• **Health Care Operations** – We may use and disclose health information about you for administrative and operational purposes. Risk management or quality improvement personnel may use health information about you to assess the care and outcomes in your case and others like it. The results will be used internally to continually improve the quality of care for all patients. For example, we may combine medical information about many patients to evaluate the need for new products, services, or treatments. We may disclose information to health care professionals, students, and other personnel for review and training purposes. We also may combine health information we have with other sources to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy and to allow others to use the information to study health care without learning the identity of the specific patients.

We may also use and disclose your medical information to:

- evaluate the performance of our staff and your satisfaction with our services;
- learn how to improve our facilities and services;
- determine how to continually improve the quality and effectiveness of the health care we provide; and
- conduct training programs or review competence of health care professionals.

• **Individuals Involved in Your Care or Payment for Your Care.** We may release health information about you to a family member or friend who is involved in your medical care. We also may give information about you to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort (such as the Red Cross) so that your family can be notified about your condition, status, and location. We may also disclose medical information about you to local authorities or utility companies if your home care is considered "life-supporting" and you require immediate attention in the event of an emergency or power outage.

• **Business Associates** – Our "Business Associates" are entities that provide services for us and that require access to certain information in order to provide those services. We provide some services, for instance, through contracts with business associates, including companies that receive phone calls from patients when our offices are closed and companies that store patient files for us. In addition, we also contract with accountants, consultants, and attorneys to provide us with services. When such services are contracted, we may disclose health information about you to our business associates so that they can perform the tasks that we have assigned to them. To protect your health information, we require the business associate to appropriately safeguard health information about you in a written agreement.

• **Reminders** – We may use health information about you to provide you with reminders about appointments.

• **Alternative Treatments** -We may use health information about you to provide you with information about alternative treatments or other health-related benefits and services that may be of interest to you.

• Future Communications – We may communicate with you via newsletters, mailings, or other means regarding treatment options, health-related information, disease management programs, wellness programs, or other community-based initiatives or activities in which we are participating.

• **Required by Law** – We may use and disclose health information about you as required by federal, state, or local law. For example, we may disclose health information for the following purposes:

- for judicial administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect, or domestic violence; and
- to assist law enforcement officials in their law enforcement duties.

• **Public Health** – We may use or disclose health information about you for public health activities, such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

• **Food and Drug Administration (FDA)** – We may use or disclose health information for purposes of notifying the FDA of adverse events with respect to medication and product defects or post marketing surveillance information to enable product recalls, repairs, or replacements.

• **Health and Safety** – We may use or disclose health information about you to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

• **Government Functions** – We may use or disclose health information about you for specialized government functions, such as protection of public officials, national security and intelligence activities, or reporting to various branches of the armed services.

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• **Medical Examiners and Others** – We may use or disclose health information about you to medical examiners, coroners, or funeral directors to allow them to perform their lawful duties. If you are an organ or tissue donor, we may use or disclose health information about you to organizations that help with organ, eye, and tissue donation and transplantation.

• **Workers Compensation** – We may use or disclose health information about you to comply with laws and regulations related to workers compensation.

• **Research** – We may use or disclose health information about you for research purposes under certain circumstances. For example, we may disclose health information about you to a research organization if an institutional review board or privacy board has reviewed and approved the research proposal, after establishing protocols to ensure the privacy of your health information.

• **Information Not Personally Identifiable** – We may use or disclose health information about you in ways that do not personally identify you or reveal who you are.

• **Law Enforcement** – We may disclose your health information to the police or other law enforcement officials as required or permitted under state law or in response to a valid court order or a grand jury or administrative subpoena.

• **Health Oversight Activities** – We may disclose your health information to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with rules of governmental health programs, such as Medicare or Medicaid.

• **Victims of Abuse, Neglect or Domestic Violence** – If this Clinic reasonably believes you are a victim of abuse, neglect or domestic violence, we may disclose your health information to the appropriate governmental authority, authorized by law to receive reports of such abuse, neglect or domestic violence.

• **Judicial and Administrative Proceedings** – This Clinic may disclose your health information in the course of a judicial proceeding in response to a legal order or other lawful purpose.

Use or Disclosure of Your Health Information <u>With</u> Your Authorization

Other uses and disclosures not described in this Notice will be made only with the individual's written authorization. You may revoke (take back) an authorization that you had previously provided by giving us written notice. In that case, we will cease using or disclosing your information for the purpose that you had authorized. The following are some examples of uses or disclosures that require your authorization:

• **Psychotherapy Notes.** We do not typically maintain psychotherapy notes on any of our patients. However, if we wanted to use or disclose any psychotherapy notes we had in our possession (for instance, as part of your medical record), we would have to ask for you authorization to do so, unless the use or disclosure was to undertake certain treatment, payment, or health care operation activities as described above.

• **Marketing.** We must obtain your authorization before we use or disclose your health information for marketing purposes, unless that marketing relates to certain treatments you are already undergoing (or available alternatives), the marketing is conducted face-to-face, or the marketing involves a promotional gift of nominal value.

• **Sale of Health Information.** This Clinic will not sell your health information to third parties for marketing purposes.

Your Health Information Rights

You have the following rights with respect to health information about you. To exercise any of your rights, please see the contact information at the end of this notice.

• **Right to Inspect and Copy** You have the right to inspect and/or obtain a copy of the health information about you that we maintain in certain groups of records that are used to make decisions about your care. You have the right to an electronic copy of your health information if it is maintained electronically. Your request must be in writing. If you request a copy of your health information, we may charge you a fee to cover the costs of copying and mailing the information. If you request a copy of your information electronically on a portable electronic media device (such as a CD or USB drive), we may charge you for the cost of that media device.

In certain very limited circumstances, we may deny your request to inspect and copy your health information. If you are denied access to your health information, we will explain our reasons in writing. You have the right to request that the decision be reviewed by another person. We will comply with the outcome of the review.

• **Right to Amend** If you feel that health information about you that we maintain in certain groups of records is inaccurate or incomplete, you have the right to request that we amend the information. You have the right to request an amendment as long as we maintain the information. Your request must be in writing and include a reason supporting the request.

In certain circumstances, we may deny your request to amend your health information. If your request for an amendment is denied, we will explain our reasons in writing. You have the right to submit a statement explaining why you disagree with our decision to deny your amendment request. We will share your statement when we disclose health information about you that we maintain in certain groups of records.

• **Right to an Accounting of Disclosures** You have the right to request an accounting or detailed listing of certain disclosures of your health information. The time period covered by the accounting is limited. Your request must be in writing. If you request an accounting more often than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

• **General Right to Request Restriction** You have the right to request a restriction or limitation on the health information about you that we use or disclose. Your request must be in writing. Please be aware that we are not required to agree to your request for restrictions. If we agree to your request for a restriction, we will comply with it unless the information is needed for emergency treatment.

• **Right to Restrict Disclosure to a Health Plan** You have the right to request that we not disclose the portion of your health information developed during a treatment that you (or someone else) paid for entirely out-of-pocket to your health plan. This request must be in writing. We may not refuse this request.

• **Right to Request Alternative Communications** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you may request that we use an alternative address for delivery or communication purposes.

• **Right to Revoke Authorization** There are occasions when you may give us written authorization to use or disclose your health information. You have the right to revoke your authorization to use or disclose health information, except to the extent that action has been taken in reliance upon your authorization.

• **Right to be Notified of a Breach** In the event some portion of your health information is lost, stolen, or otherwise improperly accessed, you have the right to be informed. You will be informed in writing, unless you have previously established a preference for electronic communications.

• **Right to Copy of Notice of Privacy Practices** You have the right to a paper copy of our Notice of Privacy Practices at any time. To obtain a copy of our current Notice of Privacy Practices, please ask the front office staff at this clinic.

Complaints

If you believe your privacy rights have been violated, you may complain to this Clinic, the Privacy Officer, and/or to the Secretary of the U. S. Department of Health and Human Services. You may make a complaint via the contact information at the end of this notice. You will not be retaliated against for filing a complaint.

Contact Information

If you have any questions, wish to obtain copies of your health information, amend, request an accounting, or exercise any other rights identified in this notice, or would like to file or discuss a complaint regarding our privacy practices, please contact this Clinic.

To Receive Additional Information or Report a Problem

For further explanation of this notice you may contact our **Privacy Officer at 1-800-580-6285**. If you believe your privacy rights have been violated, you have the right to file a complaint with our Privacy Officer or with the United States **Secretary of Health and Human Services** at **1-800-368-1019** with no fear of retaliation by this Clinic.

NOTICE OF PRIVACY PRACTICES AVAILABILITY: The terms described in this notice will be posted where registration occurs. **All individuals receiving care will be provided a hard copy upon request and asked to acknowledge receipt.**

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PATIENT DATA SHEET

First: **MI:** **Last:**

Date of Birth: **Age:** **Gender:** Male ☐ Female ☐

Physical Address:

_____

_____

_____

_____

Billing Address:

_____

_____

_____

Phone Numbers:	**OK To Call**	**Best Time To Call**
Home: _____	☐	_____
Work: _____	☐	_____
Cell: _____	☐	_____

May we send you text messages for your appointment reminders to the number(s) listed above? By marking "Yes" below, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information.

☐ Yes ☐ No

May we send you emails relating to your care with us? ☐ Yes ☐ No

By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.

Email: _____

Preferred language: _____ **Interpreter required?** ☐ Yes

Date of Injury: _____ **Referring Physician:** _____

Injury Area: _____ **Auto or Work Accident:** ☐ Auto ☐ Work ☐ N/A

Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days? ☐ Yes ☐ No

Are you currently receiving or have you received other therapy services in the last 60 days? ☐ Yes ☐ No

Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Student Status:

☐ Full-Time ☐ Part-Time ☐ None

EMPLOYMENT STATUS

Employment Status:

☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

PATIENT EMPLOYER INFORMATION

Employer: _____ **Occupation:** _____

Address: _____

_____

Phone: _____

SPOUSE EMPLOYER INFORMATION

Employer: _____ **Occupation:** _____

Address: _____

_____

Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder's Name: _____ **Holder's Birth Date:** _____

Member ID: _____ **Group #:** _____

Policy Holder's: Employer: _____

Secondary Insurance: _____

Policy Holder's Name: _____ **Holder's Birth Date:** _____

Policy or Certificate #: _____ **Group #:** _____

Policy Holder's Employer: _____

How did you hear about us?

- ☐ Ad
- ☐ AdjustorCase Manager
- ☐ Direct Access
- ☐ Doctor
- ☐ Email
- ☐ Event
- ☐ Facebook
- ☐ Family
- ☐ Friend
- ☐ Google
- ☐ Guardian
- ☐ Insurance
- ☐ Internet
- ☐ List From Doctors Office
- ☐ Mailing
- ☐ Radio
- ☐ Returning Patient
- ☐ School
- ☐ Staff
- ☐ Walk In
- ☐ Website
- ☐ Workshop
- ☐ Other

Specify if other : _____

Note: Please provide us with the most updated information below.

EMERGENCY AND OTHER CONTACTS

Name	Phone		Cell	Fax	Type

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Signature of Patient **Date**

Patient Name:

Plymouth Physical Therapy Specialists
PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C# Name A/C Type Office #

CONSENT TO TREATMENT

I consent to rehabilitation and related services at:
Plymouth Physical Therapy Specialists
In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. **Initials:** _____

TREATMENT OF MINORS

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. **Initials:** _____

LIABILITY

I know and agree that: Plymouth Physical Therapy Specialists
is not responsible for loss or damage to personal valuables. **Initials:** _____

WAIVER AND RELEASE

I hereby release, discharge and acquit: Plymouth Physical Therapy Specialists
its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. **Initials:** _____

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to: Plymouth Physical Therapy Specialists
I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. **Initials:** _____

FINANCIAL POLICY

I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

To assist in establishing your account, please:

- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf. **Initials:** _____

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practices. **Initials:** _____
I acknowledge receipt of the Statement of Patient Rights. **Initials:** _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ **Witness Signature** _____ **Date** _____

PLYMOUTH
PHYSICAL THERAPY SPECIALISTS
ORTHOPEDICS | SPORTS MEDICINE
Real Relationships. Real Results.

Patient Name: _____ **Date:** _____
Preferred Name: _____ **Preferred Pronoun:** _____

Pelvic Floor Dysfunction Summary and History Form

Why are you here today? _____

How, when, and where did your problem start? _____

_____

What improves/Worsens the problem/pain? _____

_____

Are there any symptoms that go along with the problem/pain? _____

_____

Is the problem/pain continuous, or does it come and go? _____

What is your GOAL for physical therapy? _____

_____

Have you tried any medicine/treatment or seen a doctor for this problem before this visit? (Circle those you've tried)

☐ **Physical Therapy**	☐ **Biofeedback**	☐ **Reiki**
☐ **Psychological counseling**	☐ **Acupuncture**	☐ **Kegels**
☐ **Surgery**	☐ **Injections**	☐ **Massage**
☐ **Medication**	☐ **Rest**	☐ **Meditation**

Other: _____

Referring doctor: _____ **Last seen:** _____
Family Doctor: _____ **Last Seen:** _____
OB/GYN: _____ **Last Seen:** _____
Other Specialist: _____ **Last Seen:** _____

NIH-Chronic Postatitis Symptom Index (NIH-CPSI)

Pain and Discomfort

1. In the last week, have you experienced any pain or discomfort in the following areas?
   a) Area between rectum and testicles (perineum) Y☐ N☐
   b) Testicles Y☐ N☐
   c) Tip of penis (not related to urination) Y☐ N☐
   d) Below your waist, in your pubic or bladder area Y☐ N☐
2. In the last week, have you experienced:
   a) Pain or burning during Urination? Y☐ N☐
   b) Pain or discomfort during or after sexual climax (ejaculation?) Y☐ N☐
3. How often have you had pain or discomfort in any of these areas over the last week?

0	1	2	3	4	5
Never	Rarely	Sometimes	Often	Usually	Always

4. Which number best describes your AVERAGE pain or discomfort on the days that you had it, over the last week?

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

Urination

5. How often have you had a sensation of not emptying your bladder completely after you finished urinating, over the last week?

0	1	2	3	4	5
Not at all	Less than half 1 time in 5	Less than half the time	About half the time	More than half the time	Almost Always

6.) How often have you had to urinate again less than two hours after you finished urinating over the past week?

0	1	2	3	4	5
Not at all	Less than half 1 time in 5	Less than half the time	About half the time	More than half the time	Almost Always

Impact of Symptoms

7. How much have your symptoms kept you from doing the kinds of things you would usually do over the last week?

0	1	2	3
None	Only a little	Some	A lot

8. How much did you think about your symptoms over the last week?

0	1	2	3
None	Only a little	Some	A lot

Quality of Life

9. If you were to spend the rest of your life with your symptoms, just the way they have been during the last week, how would you feel about that?

0	1	2	3	4	5	6
Delighted	Pleased	Mostly satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible

Scoring the NIH-CPSI domains

Pain: Total of items 1a, 1b, 1c, 2a, 2b, 3 and 4=_____

Urinary symptoms: Total of items 5 and 6=_____

Quality of Life impact: Total of items 7, 8, and 9=_____

Clinician Signature: _____

Date: _____

Initial

Pelvic Floor Distress Inventory

Legal Name: _____ Date: _____

Please answer each question by checking the best response. While answering these questions, please consider your symptoms over the **last 3 months.** We realize that you may not be having problems in some of these areas, but please fill out both sides of this form as completely as possible.

Urinary Distress Inventory 6 (UDI-6)

Do you experience, and, if so, how are bothered by….		1 Not at all	2 Somewhat	3 Moderately	4 Quite a bit
Usually experience frequent urination?	Yes	☐	☐	☐	☐
	No	☐	☐	☐	☐
Usually experience Urine Leakage associated with a feeling of urgency, this is, a strong sensation of needing to go to the bathroom?	Yes	☐	☐	☐	☐
	No	☐	☐	☐	☐
Usually experience urine leakage related to coughing, sneezing, or laughing?	Yes	☐	☐	☐	☐
	No	☐	☐	☐	☐
Usually experience small amounts of urine leakage (that is, drops)?	Yes	☐	☐	☐	☐
	No	☐	☐	☐	☐
Usually experience difficulty emptying your bladder?	Yes	☐	☐	☐	☐
	No	☐	☐	☐	☐
Usually experience pain or discomfort in the lower abdomen or genital region?	Yes	☐	☐	☐	☐
	No	☐	☐	☐	☐

Total _____ /6 =(mean) _____ x 25= _____

Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6)

Do you experience, and , if so, how are bothered by….		1 Not at all	2 Somewhat	3 Moderately	4 Quite a bit
Usually experience pressure in the lower abdomen?	Yes	☐	☐	☐	☐
	No	☐	☐	☐	☐
Usually experience heaviness or dullness in the pelvic area?	Yes	☐	☐	☐	☐
	No	☐	☐	☐	☐
Usually have a bulge or something falling out that you can see or feel in your vaginal area?	Yes	☐	☐	☐	☐
	No	☐	☐	☐	☐
Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	Yes	☐	☐	☐	☐
	No	☐	☐	☐	☐
Usually experience a feeling of incomplete bladder emptying?	Yes	☐	☐	☐	☐
	No	☐	☐	☐	☐
Ever have to push up on the bulge in the vaginal area with your fingers to start or complete urination?	Yes	☐	☐	☐	☐
	No	☐	☐	☐	☐

Total _____ /6 =(mean) _____ x 25= _____

Colorectal-Anal Distress Inventory 8 (CRADI-8)

Do you experience, and , if so, how are bothered by….		1 Not at all	2 Somewhat	3 Moderately	4 Quite a bit
Feel the need to strain too hard to have a bowel movement?	Yes	☐	☐	☐	☐
	No	☐	☐	☐	☐
Feel you have not completely emptied your bowel at the end of a bowel movement?	Yes	☐	☐	☐	☐
	No	☐	☐	☐	☐
Usually lose stool beyond your control if your stool is well formed?	Yes	☐	☐	☐	☐
	No	☐	☐	☐	☐
Usually lose stool beyond your control if stool is loose?	Yes	☐	☐	☐	☐
	No	☐	☐	☐	☐
Usually lose gas from rectum beyond your control?	Yes	☐	☐	☐	☐
	No	☐	☐	☐	☐
Do you usually have pain when you pass your stool?	Yes	☐	☐	☐	☐
	No	☐	☐	☐	☐
Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	Yes	☐	☐	☐	☐
	No	☐	☐	☐	☐
Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	Yes	☐	☐	☐	☐
	No	☐	☐	☐	☐

Total _____ /6 =(mean) _____ x 25= _____

Total: _____ Range= (0-300)

Clinician Signature: _____ Date: _____

Review of Genitourinary Systems

Please answer Yes (Y) or No (N) if you have ever had any of the following

Leaking with cough/sneeze	Y☐ N☐	Flank Pain	Y☐ N☐	Urinary Frequency	Y☐ N☐
Leaking with strong urge	Y☐ N☐	Kidney Failure	Y☐ N☐	Difficulty Starting Stream	Y☐ N☐
Bed wetting	Y☐ N☐	Kidney Stones	Y☐ N☐	Urine Retention	Y☐ N☐
Bladder Pain	Y☐ N☐	Leak after Voiding	Y☐ N☐	Urologic Cancer	Y☐ N☐
Blood in Urine	Y☐ N☐	Urinary Tract Infection	Y☐ N☐	Urologic Surgery	Y☐ N☐
Dribbling	Y☐ N☐	Up at Night to urinate	Y☐ N☐	Weak Stream	Y☐ N☐
Burning on Urination	Y☐ N☐	Straining to urinate	Y☐ N☐	Pads use If yes, how many in a day	Y☐ N☐ _____
Pain with Urination	Y☐ N☐	Prolapse/falling out sensation	Y☐ N☐	Double Void	Y☐ N☐
Interstim Placement	Y☐ N☐	Urgency	Y☐ N☐		

Review of Bowel/ Gastrointestinal

Acid Reflux	Y☐ N☐	Indegestion/Heartburn	Y☐ N☐	Loss of Stool	Y☐ N☐
Nausea/Vomiting	Y☐ N☐	Tarry Stools	Y☐ N☐	Pain with Bowel Movement	Y☐ N☐
Abdominal Pain	Y☐ N☐	Straining	Y☐ N☐	Hemorrhoids	Y☐ N☐
Bloody Stools	Y☐ N☐	Rectal Bleeding	Y☐ N☐	Laxative use	Y☐ N☐
Diarrhea	Y☐ N☐	Staining	Y☐ N☐	Loss of flatus (Gas)	Y☐ N☐
Constipation	Y☐ N☐	IBS	Y☐ N☐		

Musculoskeletal Review

Low Back Pain	Y☐ N☐	Osteoarthritis	Y☐ N☐	Rheumatoid Arthritis	Y☐ N☐
Osteoporosis	Y☐ N☐	Location of pain_____		Joint Pain	Y☐ N☐
		Fibromyalgia	Y☐ N☐		

Psychological Review

Anxiety	Y☐ N☐	Depression	Y☐ N☐	Other: _____	Y☐ N☐

Female Sexual Gynecological/Obstetrical

Ovarian cysts	Y☐ N☐	Vaginal Bleeding	Y☐ N☐	Sexual Dysfunction	Y☐ N☐
Endometriosis	Y☐ N☐	Vaginal Discharge	Y☐ N☐	Pain with intercourse/Penetration	Y☐ N☐
Fibroids	Y☐ N☐	STD/STI	Y☐ N☐		
Hysterectomy	Y☐ N☐	Sexually active	Y☐ N☐	Birth Control Type: _____	Y☐ N☐
Painful Periods	Y☐ N☐	Pain with Orgasm	Y☐ N☐	Pregnant	Y☐ N☐

General Health Review

Diabetes	Y☐ N☐	Irregular Heartbeat	Y☐ N☐	Memory Problems	Y☐ N☐
Heart Attack	Y☐ N☐	Dizziness	Y☐ N☐	Cancer	Y☐ N☐
Seizure	Y☐ N☐	Recent Weight Loss/Gain	Y☐ N☐		Type: _____
High Blood Pressure	Y☐ N☐	Metal Implants	Y☐ N☐	Neurological (MS. Parkinsons, etc)	Y☐ N☐
Pacemaker	Y☐ N☐	Blood Clots	Y☐ N☐		
Surgically implanted Stimulator	Y☐ N☐	Fainting spells	Y☐ N☐	Other: _____ _____ _____	

Male Sexual

Prostatitis	Y☐ N☐	Pain with Erection	Y☐ N☐	STD/STI	Y☐ N☐
Erectile Dysfunction	Y☐ N☐	Pain with Ejaculation	Y☐ N☐	Pain with Intercourse	Y☐ N☐

Have you been hospitalized before? Y☐ N☐

If yes…..

Date of Last Hospitalization and Reason: _____

Surgical History-Please list all the surgeries you have had and note date

_____

_____

_____

Social History

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life Partner ☐Common Law Spouse

Women: Date of last menstrual period: _____ Are you pregnant? Y☐ N☐

Number of Pregnancies: _____ Number of Births: _____ Are presently Nursing/Breastfeeding Y☐ N☐

Please list the year of each Cesarean Section, Vaginal, episiotomies, suction, forceps deliveries.

_____

_____

_____

Alcohol consumption	Y☐ N☐	Ocassional/Social	# Drinks/day _____
Tobacco Use	Y☐ N☐	# Packs/day _____	#Cigarettes/Day _____
Caffeinated beverages (Coffee, soda, tea)		# glasses per day _____	

Current Medications- Please list ALL medications you are currently taking, including any over-the-counter drugs on the medication card provided:

_____
_____
_____

Allergies-Please list ALL types (Drug, seasonal, pets, animals, environmental, foods, latex, etc)

_____
_____
_____

Have you ever been verbally, emotionally, sexually, or physically harmed or threatened by your partner or anyone else?
Y☐ N☐

Do you feel afraid or unsafe with your partner or anyone else? Y☐ N☐

Is anyone misusing your money, food, housing, or not allowing you to obtain healthcare? Y☐ N☐

Are you thinking of suicide? Do you have thoughts of ending your life? Y☐ N☐

I HAVE COMPLETED THIS FORM TO THE BEST OF MY KNOWLEDGE AND HAVE NOT WITHHELD ANY INFORMATION

_____

Patient signature **Date**

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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 as 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 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, strength, and endurance, scar mobility and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

Treatment may include, but not be 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 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, 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.

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.

Cancellation Policy: I understand that the 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 his/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 and elevation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapist and therapy assistants and technicians of.

Date:_____

Patient Name (print): _____

Patient signature: _____

Signature of Guardian (if applicable) _____

Witness Signature: _____

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To our Patients regarding Cancellations and No-Shows

It is our policy at Plymouth Physical Therapy Specialists to be as accommodating as possible to you, the patient, in scheduling your therapy visits, while ensuring that you succeed in your treatment with us. Your therapist has prescribed a set frequency of treatments, completing your treatment is vital to recovery.

In the event that you are unable to make one of your appointments, please call our office 24 hours in advance. We will immediately reschedule your treatment in the first available time slot.

If you do not contact us to cancel your appointment within 24 hours, there may be a $60.00 charge for failure to contact the office prior to your PT/OT appointment time. If your appointment was for a Pelvic health visit than the fee would be $100.00

When you do not show as scheduled, it hurts others that may be in pain but could not be seen on that day. This charge is not covered by your insurance carrier; it is the sole responsibility of you, the patient.

Two or three no-shows or cancellations are considered too long of a lapse in treatment, and may necessitate a new physician referral, as the program will be discontinued.

I have read, understand and agree to this policy

_____ _____

Patient Signature Date

To our Patients regarding Past Due Balances

It is our policy at Plymouth Physical Therapy Specialists to work with our patients to offer multiple forms of payments, payment plans and in some cases financial hardship adjustments.

If it is necessary to place your past due account with an outside collection agency to collect the balance due, to the extent not prohibited by applicable law, an additional 25% of the principle balance due may be added to cover the collection fees. In addition, should legal action become necessary to collect the balance due, you understand that you may be responsible for reasonable attorney's fees, interest and court costs.

I have read, understand and agree to this policy

_____ _____

Patient Signature Date

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ALL CO-PAYS/PAYMENTS ARE DUE AT TIME OF SERVICE

Our office works hard to check eligibility and benefits for our patients. However, due to the many changes and complexity of the insurance companies, it is no longer an easy task to interpret each individual policy 100%. As a courtesy, we will provide an ESTIMATE of your payment responsibility and coverage for your treatment needs. However, this is only an estimate and not a guarantee of payment from your insurance company. It is your responsibility to understand your benefits, special terms, deductibles and copay's with your insurance company.

Thank you,

PLYMOUTH PHYSICAL THERAPY SPECIALISTS

Patient Signature:_____