Newport Physical Therapy

1010 SW Coast Highway
Newport, OR 97365

Last Name:_____ First Name: _____Middle:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Physician:_____

Employer:_____ Address:_____ Work Phone:_____

Date of Birth:_____ Social Security #:_____ Email:_____

Emergency Contact: Name_____Contact Number_____
Relationship To Patient:_____

Primary Insurance

Primary Insurance:_____ Subscriber's Name:_____

Subscriber ID #:_____ Subscriber DOB:_____ Group #:_____
(If you're not the card holder please give card holders info this is very important)

Secondary Insurance

Secondary Insurance:_____ Subscriber's Name:_____

Subscriber ID #:_____ Subscriber DOB:_____ Group #:_____

Automobile Accident/Workers Compensation

Injury caused by: Auto Accident: Y or N Workers comp: Y or N Date of Injury:_____

Insurance Company:_____

Claim Number: _____Contact:_____ Phone:_____

Name of Insurance company to bill:_____

I have read this in its entirety and agree to the above statements; also, all patients and insurance information I have given above is correct to the best of my knowledge.

_____ Date:_____
Signature of Patient or Guardian (if patient is under the age of 18)

Patient Medical History

Name:_____ Referring Physician:_____

Primary Care Physician:_____ Date of last visit with PCP:_____
Date first Dr. Visit for the injury/episode:_____ Last day worked for this injury:_____
Date returned to work after injury:_____ Is an Attorney involved in this case:_____

Have you had surgery for this injury:_____ Type of surgery:_____
Date of surgery:_____ Have you had Physical Therapy within the past year:_____

Are you currently taking any prescription or non-prescription medications? YES or NO
Anti-Inflammatory:_____ Muscle Relaxers:_____ Pain Medications:_____
List Medications or we can copy a list if you already have it:_____
Are you allergic to any medication? Yes or No List Medications:_____
Are you allergic to latex or adhesives? Yes or No

Height:_____ Weight:_____

Have you had any of the following Medical or Rehabilitative Services for this injury/episode? Please mark how many visits you have had for Physical, Occupational and Speech Therapy for this year.

	# Visits				# Visits		
Chiropractor		YES	NO	CT Scan		YES	NO
EMG/NCV		YES	NO	General Practitioners		YES	NO
Massage Therapy		YES	NO	MRI		YES	NO
Myelogram		YES	NO	Neurologist		YES	NO
Occupational Therapy		YES	NO	Orthopedist		YES	NO
Physical Therapy		YES	NO	Podiatrist		YES	NO
Emergency Room Care		YES	NO	X-Ray's		YES	NO
Speech Therapy		YES	NO				

Do you have or you had ANY of the following? PLEASE CIRCLE

Asthma	Bronchitis	Emphysema	Shortness of Breath	Chest Pain	Coronary Heart Disease
Stroke	Numbness	Blood Clot	High Blood Pressure	Anemia	Do you have a pacemaker
Goiter	Epilepsy	Seizures	Heart Attack/Surgery	Gout	Congestive Heart Disease
Diabetes	Tingling	Allergies	Thyroid Disease	Hernia	Arthritis RA OA
Radiation	Chemotherapy	Any Pins	Pregnant	TIA	Osteoporosis
Dizziness	Weight Loss	Elbow Injury	Sleeping Problems	Cancer	Infectious Disease
Fainting	Energy Loss	Hand Injury	Tobacco Use	Vision	Hearing Difficulties
Knee Injury	Metal Implants	Back Injury	Severe Headaches	Varicose Veins	Frequent Headaches
Leg Injury	Foot Injury	Ankle Injury	Shoulder Injury	Neck Injury	Joint Replacement Surgery

PELVIC FLOOR QUESTIONNAIRE

Name_____**Physician**_____**Date**_____

Please describe your main problem_____

_____

When did it begin?_____ Is it getting: better, worse, or staying the same (circle one)

Please describe activities or things that you cannot do because of your problem.

_____

_____

Please list all pelvic and abdominal surgeries with dates of operation.

_____

_____

Date of last pelvic examination_____Date of last urinalysis_____

Special Tests Performed?_____Type_____Date_____

1. OCCURRENCE OF INCONTINENCE OR LEAKAGE
   - Never
   - Less than 1/month
   - More than 1/month
   - Less than 1/week
   - More than 1/week
   - Almost every day
   - #___ leaks per day

2. PROTECTION USED
   - No Protection
   - Pantishields
   - Mini Pad
   - Maxi Pad
   - Bladder control pad type_____
   - Diaper

3. SEVERITY
   - No leakage
   - Few drops
   - Wet underwear
   - Wet outerwear

4. POSITION OR ACTIVITY WITH LEAKAGE
   - Lying down
   - Sitting
   - Standing
   - Changing positions (sit to stand)
   - Sexual activity
   - Strong Urge

5. HOW LONG CAN YOU DELAY THE NEED TO URINATE?
   - Indefinitely
   - 1+ hours
   - ½ hour
   - 15 minutes
   - Less than 10 minutes
   - 1-2 minutes
   - Not at all

6. ACTIVITY THAT CAUSES URINE LOSS
   - Vigorous activity
   - Moderate activity
   - Light activity
   - No activity
   - Type_____

7. PROLAPSE (Falling Out Feeling)
   - Never
   - Occasionally/with menses
   - Pressure at the end of the day
   - Pressure with straining
   - Pressure with standing
   - Perineal pressure all day

8. FREQUENCY OF URINATION (DAYTIME)
   - 0 times per day
   - 1-4
   - 5-8
   - 9-12
   - 13+

9. FREQUENCY OF URINATION (NIGHTTIME)
   - 0 times per night
   - 1
   - 2
   - 3
   - 4+

10. FLUID INTAKE
   - Includes water and beverages
   - 9+ 8oz glasses per day
   - 6-8 8oz glasses per day
   - 3-5 8 oz glasses per day
   - 1-2 8 oz glasses per day
   - How many caffeinated glasses? _____

11. FREQUENCY OF BOWEL MOVEMENTS
   - 2 times per day
   - 1 time per day
   - Every other day
   - Once every 4-7 day
   - Weekly

12. AFTER STARTING TO URINATE, CAN YOU COMPLETELY STOP THE URINE FLOW?
   - Can stop completely
   - Can maintain a deflection of the stream
   - Can partially deflect the urine stream
   - Unable to deflect or slow the stream

13. DO YOU HAVE TROUBLE INITIATING A URINE STREAM?
   - Never
   - More than 1/month
   - Less than 1/week
   - Almost every day

14. ATTITUDE TOWARDS PROBLEM
   - No problem
   - Minor inconvenience
   - Slight problem
   - Moderate problem
   - Major problem

15. CONFIDENCE IN CONTROLLING YOUR PROBLEM
   - Complete confidence
   - Moderate confidence
   - Little confidence
   - No confidence

16. Are you sexually active? Yes_____ No_____
   Are you pregnant or attempting pregnancy? Yes_____ No_____
   Number of pregnancies?_____ Complications?_____
   _____

17. History of or present sexually transmitted diseases? Type_____
_____

18. Do you have pain or problems with sexual activity or urination?
Describe_____
_____

19. Have you ever been taught or prescribed to do pelvic floor/Kegel exercises ?

Yes___No____When?_____ By whom?_____

20. How often do you do pelvic floor exercises?_____

Any comments or concerns not asked?

_____

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 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.

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.

1. The purpose, risks, and benefits of this evaluation have been explained to me.
2. I understand that I can terminate the procedure at any time.
3. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation.
4. I have the option of having a second person present in the room during the procedure and _____ choose _____ refuse this option.

Date: _____ Patient Name: _____

_____ _____

Patient Signature Signature of Parent or Guardian (if applicable)

_____

Witness Signature

Newport Physical Therapy

1010 SW Coast Highway, Suite 102
Newport, Oregon 97365

Financial Policy

1. Medical services will be billed to your Insurance Company (limit of two companies): however, we are not acting as an agent for your Insurance Company and we assume no responsibility for collection of any proceeds of Insurance. You are responsible for all deductibles and charges not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged Insurance negotiations, this is your responsibility.

2. Most insurance plans have a Deductible that must be met before the insurance will pay for services rendered. **We will collect $75.00 at the beginning of each visit that will be applied to your Deductible.** When we receive the Explanation of Benefits (EOB) from your insurance, the remaining balance due per visit will be billed to you in the beginning of each month.

3. Many people are under the impression that if they have insurance: it is the Insurance Company that owes the Health Care Provider for the services provided. This is not the case. The Insurance contract is between the patient and the Insurance Company. Therefore, the patient is responsible for the bill, regardless of insurance coverage.

4. The balance of the account is due in full within 60 days of service, unless prior payment arrangements have been made. Delay or denial of payment by your Insurance Company does not relieve you of responsibility for payment.

5. Motor Vehicle or Other Liability Claims : We bill Insurance Companies for such claims; however, settlement of these claims can take many months. A suit against another party is not a reason to delay payment for physical therapy services. We ask that you work with our billing department to make suitable payment arrangements.

6. Delinquent accounts will be referred to a collections agency at the discretion of the Office Manager. If any legal action is initiated by us or by our agents, the undersigned will be responsible for any collection fees including agency and attorney fees and court costs. There is a $25.00 fee for all returned checks.

7. **A 24 HOUR 'BUSINESS DAY' NOTICE IS REQUIRED FOR CANCELLATIONS.**
   -FOR EACH CLINIC CANCELLATION, THE FEE IS $40.00
   -FOR "NO SHOW" APPOINTMENTS, THE FEE IS $50.00.
   -FOR SWIMMING POOL "NO SHOW" FEE IS $50.00.
   ***IF YOUR INSURANCE COMPANY WILL NOT ALLOW US TO CHARGE YOU FOR MISSING AN APPOINTMENT, YOU WILL BE EXEMPT FROM THE ABOVE FEES.**
   ****HOWEVER, MULTIPLE SAME DAY CANCELLATIONS OR "NO SHOWING" OF YOUR APPOINTMENT CAN & WILL AFFECT YOUR CARE WITH US, REGARDLESS OF YOUR INSURANCE STATUS. YOU WILL BE DISCHARGED FROM OUR CARE UPON THE SECOND INCIDENT OF CANCELLATION/NO SHOW.**

I understand and agree to the above terms. I authorize the release of any medical information necessary to process my insurance claims and authorize payment of health care benefits to the physical therapist/clinic. I authorize the use of fax machine or other electronic transfer data as required for claim processing.

_____ _____

Signature Date

PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS INFORMATION CAREFULLY.

1. Your confidential healthcare information may be released to the following:
    a. Other healthcare professionals for the purpose of providing you with quality healthcare.
    b. Your insurance providers for the purpose of receiving payment for providing you with needed healthcare services.
    c. Public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic abuse.
    d. Other healthcare providers in the event you need emergency care.
    e. Public health organization or federal organization in the event of a communicable disease or to report a defective device or event to a biological product (food or medication).
2. Your confidential healthcare information may not be released for any other purpose than which is identified in this notice.
3. You may be contacted by Newport Physical Therapy to remind you of any appointments.
4. You have the right to restrict the use of your confidential healthcare information. However Newport Physical Therapy may choose to refuse your restriction if it is a conflict of providing you with quality healthcare or in the event of an emergency situation.
5. You have the right to receive confidential communications about your health status.
6. You have the right to complain to Newport Physical Therapy if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, you may contact Newport Physical Therapy or mail your complaint:

Newport Physical Therapy

1010 SW Coast Hwy, Suite 102

Newport, Oregon 97365

541-265-4252

Signature Date