SOUTHWEST FLORIDA PELVIC HEALTH CLINIC

Last Name: _____First Name:_____ MI:_____

Date of Birth: _____ Age: _____ Male or Female: _____

Home Address: _____ City_____ Zip_____

Are you seasonal: YES _____ No_____ If so, what is your other address?

"North" Address: -_____ City_____ State_____ Zip_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Are you employed? Yes____ No____

Employer: _____ Full or Part time?_____

Occupation:_____

Primary Language Spoken: _____

Ethnicity: ____non-Hispanic ____ Hispanic ____Other Race: _____African American _____Asian _____Caucasian ____Hispanic ____ Native American _____Other

Referring Doctor: _____

Marital Status: ____ Married _____Single ____Widowed _____ Divorced

Emergency Contact (EC) / Release of Information (ROI)- Please Check the Boxes that Apply: Name of Person to Contact in case of Emergency/ or we may release information to:

Name: _____ Phone: _____Relationship: _____ EC___ ROI___

Name: _____ Phone: _____Relationship: _____EC __ROI__

Name: _____Phone: _____Relationship: _____ EC___ ROI___

Notice of Privacy Practices Acknowledgement

I acknowledge that I have been given a copy of or an opportunity to read the practice's Notice of Privacy Practices.

_____ _____

Patient's or Guardian's Signature Date

SOUTHWEST FLORIDA PELVIC HEALTH CLINIC

Payment Agreement

Thank you for choosing Southwest Florida Pelvic Health Clinic, LLC as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

- You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved. 0
- Payment is expected at time of service unless you have made other payment arrangements with us.
- **Out-of-Network Policy.** (Commercial Health Plans - Does not apply to Medicare) We are out-of-network with all health plans. If you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You understand that you may be required to pay a higher copay or coinsurance for out of network services if you have any out of network benefits at all. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.
- **Tri-Care Policy.** We are out-of-network with all Tri-Care Plans. If your Tri-Care plan will reimburse you for out of network services, we will give you a copy of your bill that you can, at your discretion, submit to Tri-Care for reimbursement for the services your health plan covers. You are responsible for obtaining any physician referrals and/or pre-authorizations that might be required.
- **Medicare Policy (for Medicare Part B and Medicare Advantage Plans).** If you are a Medicare beneficiary, you understand that our licensed physical therapists are ***not*** enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide. Since we are not enrolled providers, we cannot submit claims to Medicare ***and*** Medicare will not pay for our services even though the same services might be paid by Medicare if you obtained them from a Medicare enrolled provider. If you want Medicare to pay for services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. If you decide at any point after you start services with us that you want Medicare to pay for the services it covers, we will be happy to recommend a Medicare enrolled provider and terminate your services with us. As a condition of us providing services to you, you are choosing, of your own free will, not to use your Medicare benefits and agreeing to pay privately at the time of service for all services you elect to receive from us with no expectation that Medicare will reimburse you. You understand that we will not submit claims to Medicare on your behalf and agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.
    - **Medicare supplemental insurance plans.** If your Medicare supplemental insurance plan will reimburse you for medically necessary services by providers not enrolled with Medicare, we will provide you with a letter stating we are not enrolled as a Medicare provider and a statement that you can submit to your supplemental plan. However, you should be prepared that your supplemental plan may not pay for services by providers not enrolled with Medicare. If your supplemental plan requires you to obtain a denial from Medicare before it will pay for your services, we cannot submit a bill to Medicare merely to get a denial because we are not enrolled providers.
    - **Medicare as a Secondary Payer.** If you have a commercial insurance plan, we will provide you with a copy of your bill that you can, at your discretion, submit to your commercial health plan for reimbursement for the services your health plan covers. However, since we are not Medicare enrolled providers, Medicare will not pay your copays, co-insurance or deductibles as a secondary payer. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement of copays, coinsurance or deductibles that your commercial health plan does not pay.
- **Cancellation Policy.** We require a 24-hour notice to cancel a scheduled appointment. If you cancel with less notice, you will be required to pay a $50 late cancellation/no show penalty fee. We reserve the right to waive this policy at our sole discretion.
- **Privacy Rights.** You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately

for your services at the time of service. If you pay for your services at the time of service, we assume you are exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will disclose your health information.

- **Appeals Policy.** You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.
- **Service Termination Policy.** If we determine at any time that conditions in your home create a potentially unsafe environment for our providers, we may, at our sole discretion, terminate our services with you. If we do so, we will make reasonable efforts to refer you to the services you need to resolve the issue that is causing a potentially unsafe environment.

I HAVE READ, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS.

I acknowledge that I have chosen, of my own free will, to obtain the services provided by Southwest Florida Pelvic Health Clinic, LLC and have agreed to pay out of pocket for my services without any expectation that my health plan will reimburse me. If I am a Medicare beneficiary, I attest that I have chosen not to use my Medicare benefits for the services I am purchasing and am restricting Southwest Florida Pelvic Health Clinic, LLC and my therapist from submitting any claims to Medicare pursuant to my right to privacy under HIPAA.

Patient Name (Print or Type): _____

X _____ Date: _____

Patient's Signature

A photocopy of this agreement is to be considered valid, the same as if it was the original.

SOUTHWEST FLORIDA PELVIC HEALTH CLINIC

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. Benefits of treatment 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.

Potential Risks and Alternatives. I understand that 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. If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physical therapist or treating physician.

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 for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss all treatment options with me before I consent to treatment. I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided.

I have read this consent form, understand the benefits and risks involved in my physical therapy treatment plan, and agree to fully cooperate and participate in the proposed physical therapy interventions in the established plan of care. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation or want to request having a second person present in the room when I am being treated.

Patient's Name (Printed) _____

Patient's Signature _____ Date_____

Parent/Guardian Signature_____ Date_____

SOUTHWEST FLORIDA PELVIC HEALTH CLINIC

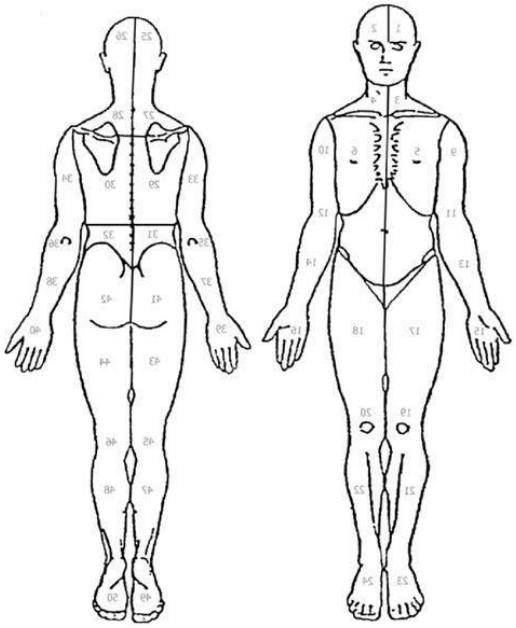
Patient Name: _____Date: _____
Referring Physician / Source: _____ Primary Care Physician:_____

Assess Your Pain: Where is your pain and where does it go?_____

When did it start? _____

Intensity - on a scale of 1 – 10, with 1 being the lowest and 10 being the highest, please rate your pain below.

0 1 2 3 4 5 6 7 8 9 10 On the diagram at the right, please indicate where your pain is located.



Please describe your pain (check all that apply): □SHARP □DULL □BURNING □ACHING □THROBBING
□OTHER_____ □CONSTANT □INTERMITTENT

I have: □pins and needle sensation □loss of sensation □muscle weakness

Have you experienced bowel or bladder changes?

□Yes □No

Does the pain affect your sleep? □Yes □No

List the activities that increase your pain:

_____

Medical History: Please list all current medications and dosage that you are currently taking: _____
_____ _____ _____ _____ _____
_____ _____ _____ _____

Please list any allergies to medication or other allergies that you have: _____
_____ _____ _____ _____

Please list any medical or health problems that you have now or had in the past: _____
_____ _____ _____ _____ _____
_____ _____ _____

Please list any surgeries that you have had, giving dates and procedure: _____
_____ _____ _____ _____

_____

Family / Social History:

Please check any medical problems that run in your family:

□HEART DISEASE □LUNG DISEASE □LIVER DISEASE □KIDNEY DISEASE □GI DISORDERS □DIABETES □STROKE

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Do you drink alcohol? □Yes □No If yes, how often? _____

Do you smoke? □Yes □No If yes, how much/long? _____

Do you use illegal substances? □Yes □No If yes, what? _____

Constitutional Symptoms Fever □Yes □ No Chills □Yes □ No Headache □Yes □ No
Other:_____

Eyes: Blurred Vision □Yes □ Double Vision □Yes □ No Pain □Yes □ No
Other:_____

Allergic/Immunologic: Hay Fever □Yes □ No Drug Allergies □Yes □ No
Other_____

Neurological : Tremors □Yes □ No Dizzy Spells □Yes □ No Numbness/Tingling □Yes □ No
Other:_____

Endocrine : Excessive Thirst □Yes □ No Too hot/cold □Yes □ No Tired/Sluggish □Yes □ No
Other_____

Gastrointestinal : Abdominal pain □Yes □ No Nausea/Vomiting □Yes □ No

GERD/heartburn □Yes □ No Other_____

Integumentary : Skin rash □Yes □ No Boils □Yes □ No Persistent Itch □Yes □ No
Other_____

Musculoskeletal: Joint Pain □Yes □ No Neck Pain □Yes □ No

Pain □Yes □ No Other_____

Ear/Nose/Throat/Mouth : Ear infection □Yes □ No Sore throat □Yes □ No

Sinus problems □Yes □ No Other_____

Genitourinary : Urine retention □Yes □ No Painful urination □Yes □ No

Urinary frequency □Yes □ No Other_____

Respiratory : Wheezing □Yes □ No Frequent Cough □Yes □ No

Shortness of breath □Yes □ No Other _____

Hematologic/Lymphatic: Swollen glands □Yes □ No Blood clotting prob. □Yes □ No
Tired/Sluggish □Yes □No Other_____

Psychological Depression □Yes □ No Suicidal thoughts □Yes □ No

Dissatisfied with life □Yes □ No