

Southwest Florida Pelvic Health Clinic

CLIENT INTAKE FORM

Last Name: _____ First Name: _____

Date of Birth: _____ Age: _____

Male Female Transgender Non-Binary Prefer not to respond

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

Are you seasonal? Yes No If so, what's your other address?

“North” Address: _____ City: _____ State: _____ Zip: _____

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

Email Address: _____

Are you Employed? Yes No

Employer: _____ Occupation: _____

Marital Status: Married Single Widowed Divorced

How did you learn about us? _____

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.
- 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 **\$75 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.

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PAYMENT AGREEMENT

- **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's Name (Printed) _____

Patient's Signature _____

Date _____

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

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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 _____

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Last Name: _____ First Name: _____

Referring Physician: _____ Primary Care Physician: _____

Please describe the current problem that brought you here? _____

Are you experiencing pain? If so, where does it travel? _____

When did the problem begin? _____ years ago _____ months ago

Previous treatment or therapy? (Describe) _____

Level of Pain (0=no pain, 10=worst pain):

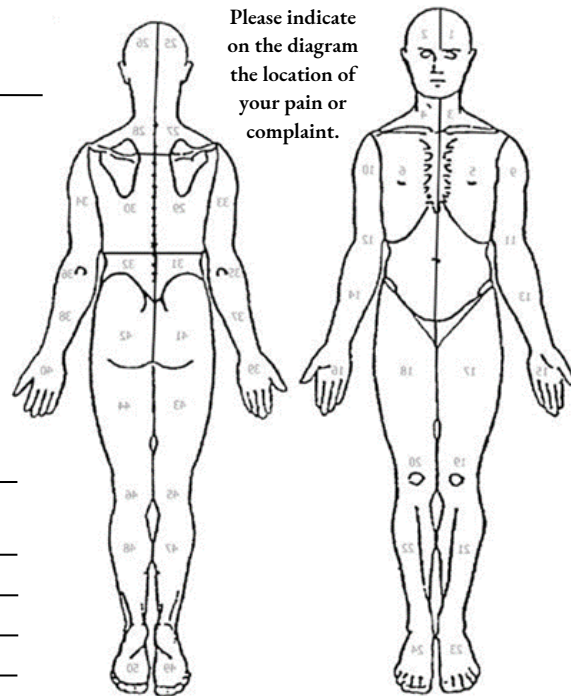
Best Pain: Worst Pain: Current Pain:

Describe your pain (check all that apply):

- Sharp Dull Burning Aching Pins & Needles
 Throbbing Constant Intermittent Loss of Sensation
 Muscle Weakness Other _____

List activities that increase your pain: _____

List any surgeries, procedures & previous medical history: _____



Have you ever experienced bladder or bowel changes? Yes No _____

Are you sexually active? Yes No Date of last pap: _____ Normal Abnormal

Do you experience pain or discomfort with intercourse? Yes No If yes, please describe.

Do you ever have the sensation of something falling out, pelvic heaviness or pressure? Yes No If yes, please describe.

Do you ever experience pelvic or lower abdominal pain? Yes No If yes, please describe.

Date of last menstrual cycle _____ Painful/heavy periods? Yes No

of Pregnancies _____ # of Deliveries _____ # of Miscarriages _____

Deliveries (List dates & birth weights) _____

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Medications or Supplements	Reason	Dosage	Started Taking

Allergies to medications, foods or other: _____

Constitutional Symptoms:

Fever Yes No

Chills Yes No

Other: _____

Eyes:

Blurred Vision Yes No

Pain Yes No

Double Vision 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

Persistent Itch Yes No

Boils Yes No

Other: _____

Musculoskeletal:

Joint Pain Yes No

Neck Pain Yes No

No Pain Yes No

Other: _____

Ear/Nose/Throat/Mouth:

Ear Infection Yes No

Sinus Problems Yes No

Sore Throat Yes No

Other: _____

Genitourinary:

Urine Retention Yes No

Urinary Frequency Yes No

Painful Urination Yes No

Other: _____

Respiratory:

Wheezing

Frequent Cough Yes No

Shortness of Breath Yes No

Other: _____

Hematologic/Lymphatic:

Swollen Glands Yes No

Blood Clotting Yes No

Problems Yes No

Tired/Sluggish Yes No

Other: _____

Psychological:

Depression Yes No

Suicidal Thoughts Yes No

Dissatisfied with Life Yes No

Other: _____