

INFORMED CONSENT & GUIDELINES

PATIENT NAME: _____

PATIENT GUIDELINES

Thank you for selecting Endurance Physio for your physical therapy needs. Please understand that for your treatment benefit to be maximized, you must regularly attend your therapy appointments and perform your home exercises and/or instructions. You should notice a direct relationship between your commitment and your improvement!

Please understand that you are responsible for scheduling and keeping appointments. All our time is valuable, and in an effort to respect your time and that of our therapists and other patients, we require a ONE BUSINESS DAY notice to change or cancel your appointment. We understand we all have busy lives and things come up last minute, however, late cancellations and no shows are subject to a \$50 cancellation fee.

Endurance Physio will be responsible for billing your insurance company and you will receive a statement accordingly. Although we make an effort to understand all our patient's physical therapy benefits, ultimately it is your responsibility and you are responsible for charges that are not reimbursed by your insurance.

RELEASE OF INFORMATION AUTHORIZATION

I authorize my referring provider to release my medical records to Endurance Physio for their file relating to my physical therapy diagnosis. Endurance Physio may request such information as my medical chart, provider notes, radiology and/or operative reports.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been shown a printed copy of the Notice of Privacy Practices and consent to the provisions of this notice. I understand that a copy of this Notice is available for download on the Endurance Physio website (endurancephysio.net) should I want my own copy.

INFORMED CONSENT

I acknowledge that I have been informed that physical therapy involves participation in activities to increase strength, balance, etc. via exercise and modalities which carry a risk of exacerbation of symptoms or other injury. I am signing this form with full knowledge of the associated risks.

This consent form will remain in effect until renounced. A photocopy of this document is considered as valid as this original. We appreciate your cooperation throughout your therapy with us. We are excited to work with you towards your treatment goals.

Signature: _____ Date: _____
(Patient, Parent, or Legal Guardian)

If signed by a patient representative, indicate relationship to patient: _____

AGREEMENT OF FINANCIAL RESPONSIBILITY

PATIENT NAME: _____

Thank you for choosing us as your healthcare provider. We are committed to providing quality care and service to all our patients. The medical services you seek imply a financial responsibility on your part. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment. Feel free to ask if you have any questions regarding your financial responsibility.

- Please understand the payment of your bill is considered part of your treatment. We accept cash, check, credit/debit cards, and pre-approved insurance.
- Providing your insurance information does not guarantee coverage is effective or that the services rendered will be covered by your insurance company.
- It is your responsibility to know your own insurance policy, eligibility, and benefits, including:
 - Whether we are In-Network or Out-of-Network with your insurance company
 - Exclusions in your policy
 - Referral requirements of your insurance plan
 - Pre-authorization/precertification requirements of your insurance plan
 - Deductibles, co-insurance, and copayment amounts
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information. Denied claims are subject to a minimum patient responsibility of \$200 if unable to resolve.
- If we are contracted with your insurance company we will bill your insurance company. You are responsible for deductibles, co-payments, co-insurance amounts and/or any other patient responsibility indicated by your insurance carrier or our policies.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, copayments, and benefits that differ greatly from In-Network benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

CARD ON FILE POLICY

We require a card on file for all patients who have a copay or elect to pay Fee at Time of Service (\$150). To reduce medical billing and back-end collection costs, the card on file will be charged for copays and Fees at Time of Service at check-in.

PAYMENT PLANS

Payment plans can be set up upon request. Please let front desk staff or your therapist know if you think you might need to set up a payment plan.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature: _____ Date: _____

(Patient, Parent, or Legal Guardian)

If signed by a patient representative, indicate relationship to patient: _____

MEDICAL INFORMATION

NAME: _____ DATE: _____

Are you currently working? Y N If so, how many hours per week? _____

Occupation: _____

Are you right or left hand dominant? Right Left

Do you use tobacco products? Y N If yes, amount per day? _____

Are you pregnant? Y N

CHECK ALL THAT APPLY:

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma, difficulty breathing | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes, hypo/hyperglycemia | <input type="checkbox"/> Dizziness or vertigo |
| <input type="checkbox"/> Fainting, seizures | <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart condition or pacemaker |
| <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Injury to head, chest, organs | <input type="checkbox"/> Lung disorder |
| <input type="checkbox"/> Mental condition | <input type="checkbox"/> Night pain | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Severe illness | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Swelling, joint pain | <input type="checkbox"/> Vision or hearing problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Significant weight loss/gain |

OTHER RELEVANT MEDICAL HISTORY OR ISSUES:

SURGERY HISTORY:

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Have you experienced any of the following in the last three months? (check all that apply)

- | | | | |
|---|---|-------------------------------------|--------------------------------|
| <input type="checkbox"/> Subtle onset of pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Night pain | |

CURRENT CONDITION

What are we seeing you for today? _____

Is the issue from a recent injury or is it chronic? _____

When did it happen/start? _____

How did it happen? _____

What makes it better? _____

What makes it worse? _____

Have you had medical testing such as x-rays, MRIs, etc? (circle one) YES NO

Have you tried physical therapy for this issue before? (circle one) YES NO

On a scale of 1 - 10 (1 being no pain, 10 being the worst pain), how do you feel:

Right now: _____ At your worst: _____ At your best: _____

How much does your pain affect your ability to do the activities you want to do? (mark one)

Not at all. A little bit. A lot. Activities are impossible.

What was your pre-injury activity level:

What is your current activity level and do you experience pain during or after these activities?

What are your goals for physical therapy?

Use the figures (right) to indicate your pain symptoms:

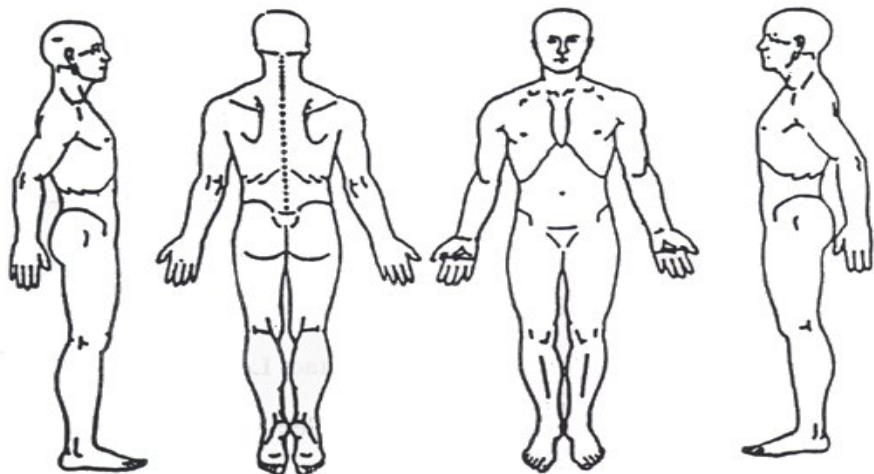
A = Ache

S = Stabbing

R = Radiating

P = Pins & Needles

O = Other



PELVIC FLOOR THERAPY QUESTIONNAIRE

NAME: _____ DATE: _____

Please fill out the following questionnaire to the best of your ability. Your therapist will review the answers with you during your visit.

HISTORY

Number of pregnancies: _____ Number of vaginal deliveries: _____
Birth weight of largest baby: _____ Number of cesarean deliveries: _____
Number of episiotomies: _____ Date of last pap smear: _____

Did you have trouble healing after delivery? Y N
Do you have a history of sexual abuse or trauma? Y N
Are you having regular periods/menstrual cycles? Y N
Do you have frequent urinary tract infections? Y N

PELVIC PAIN

Do you have pain with:

Sexual intercourse? Y N
Pelvic exam? Y N
Tampon use? Y N

Do you have back, leg, groin, or abdominal pain? Y N

MEDICAL TESTS & RESULTS

Please indicate if you have completed any of the below tests. Provide the test results if known.

Urodynamics Test Y N Results: _____
Cystoscope Y N Results: _____
Urine Test Y N Results: _____
Bowel Test Y N Results: _____

PELVIC FLOOR THERAPY QUESTIONNAIRE

BLADDER SYMPTOMS

Do you lose urine when you:

Cough, sneeze, laugh?	Y	N	Lift, exercise, dance?	Y	N
Are on the way to the bathroom?	Y	N	Have a strong urge to urinate?	Y	N
Hear running water?	Y	N	Other: _____		

Do you:

Wet the bed?	Y	N
Have burning/pain with urination?	Y	N
Have difficulty starting a stream of urine?	Y	N
Have to strain to empty your bladder?	Y	N
Feel unable to empty your bladder fully?	Y	N
Have a falling out feeling?	Y	N
Have pain with a full bladder?	Y	N
Have an urgency of urination? (<i>strong urge to urinate</i>)	Y	N
Urinate more than 7 times per day?	Y	N

BOWEL SYMPTOMS

Do you:

Have to strain to have a bowel movement?	Y	N
Include fiber in your diet?	Y	N
Take laxatives/enema regularly?	Y	N
Have pain with bowl movements?	Y	N
Have a very strong urge to move your bowels?	Y	N

How often do you move your bowels? _____ times per day; _____ times per week

Most common stool consistency?

Liquid Soft Firm Pellets Other: _____

