restore
PHYSICAL THERAPY

GENERAL INFORMATION:

First Name: _____

Middle Name: _____

Last Name: _____

Preferred Name: _____

SSN: _____ - _____ - _____

Birthdate: _____ / _____ / _____

Gender: Male/Female

Pronouns: He/Him, She/Her, They/Them, Prefer Not to Say

MINOR: ⬭

Parent/Guardian Name: _____

Address: _____

Phone: _____

Birthdate: _____ SSN: ____ - ____ -

Employer: _____

ADDRESS INFORMATION:

Billing Address: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

CONTACT INFORMATION:

Primary Phone: _____ Cell/Home/Work

Secondary Phone: _____ Cell/Home/Work

Email: _____

Appointment Text Reminder*: ⬭

*Note by checking the text reminder box you authorize certain PHI to be disclosed (ie: name, email, appointment information)

OCCUPATION: _____

Employer: _____ Phone: _____

Business address: _____

EMERGENCY CONTACT:

Name: _____ Ph: _____

Address: _____ Relation: _____

Closest Relative or Friend (not living with you):

Name: _____ Ph: _____

Address: _____ Relation: _____

MARITAL STATUS: Single/Married/Widow/Divorce

Spouse Name: _____

Employer: _____ Ph: _____

REFERRING PHYSICIAN: _____

FACILITY: _____

PRIMARY CARE PHYSICIAN (PCP): _____

FACILITY: _____

INSURANCE INFORMATION:

Primary Insurance: _____

ID#: _____ Grp#: _____

Insurance Phone #: _____

Claims Address: _____

Secondary Insurance: _____

ID#: _____ Grp#: _____

Insurance Phone #: _____

Claims Address: _____

CLAIM TYPE: Motor Vehicle Accident/Workman's Comp

If yes, Date of injury: _____ State: _____

Claim #: _____

Date of Surgery (if applicable): _____

Do you have a follow-up appointment with the doctor who referred you to physical therapy?

- ○ YES, date of appointment: _____
- ○ NO, I am to call the doctor to schedule a follow up
- ○ NO, doctor did not request to see me again

Restore Physical Therapy is committed to providing quality physical therapy at reasonable cost. It is our policy to collect all accounts receivable within 90 days from date of service.

For those patients with insurance coverage, we bill regularly. ***However, the patient is responsible to understand the specifics of their individual insurance coverage. The insurance contract is between the covered individual and the insurance company***. The patient retains ultimate responsibility for financial charges incurred as a result of treatment. Our staff is available for assistance with insurance billing questions.

CONSENT FOR TREATMENT

I hereby consent to such physical therapy procedures as may be rendered by Restore Physical Therapy. There is also consent for authorization of all insurance benefits to be paid directly to Restore Physical Therapy, and assumption of all financial responsibility for the balance of charges not included in the insurance coverage. ***A $20.00 fee will be charged for returned checks.*** Restore Physical Therapy has the authority to disclose medical information for treatment, payment and health operations. Restore Physical Therapy is released from disclosure of the patient's records as provided by this paragraph.

LESS THAN 24-HOUR CANCELLATION/NO SHOW POLICY:

It is important that you attend your scheduled appointments. It is difficult for us to assist you when you are not here. ***We do charge the patient, not the insurance a $50 fee for cancellations less than 24-hour notice and/or if you no show to your appointment. If you arrive 10 minutes or more late, your appointment will be cancelled and rescheduled and the less than 24-hour cancellation fee would be applied to your account. After 2 no shows, all future appointments will be canceled, and you will be on a call list. You will be discharged as a patient if you have 3 cancellations less than 24-hours and/or 3 no show appointments.*** Every attempt will be made to make your physical therapy appointments as convenient as possible.

HIPAA NOTIFICATION

I acknowledge that I have been informed and notified of the whereabouts of Restore Physical Therapy's notice of information practices (how medical information regarding myself may be used and disclosed and how I can get access to this information).

_____

Patient or Guardian Signature **Date**

restore
PHYSICAL THERAPY

PELVIC FLOOR INTAKE

Name: _____ Date: _____

Preferred Name: _____ Referring Physician: _____

Preferred Pronouns: She/Her He/His They/Them DOB: _____

Please describe your main problem: _____

_____

_____

When did it begin_____ Is it getting: better / worse / no change

Please describe activities that you are unable to do because of this problem: _____

_____

Medical History

Do you have or have had:	Yes	No
Diabetes		
Osteoarthritis		
Osteoporosis		
Rheumatoid Arthritis		
Headaches		
Cancer		
High Blood Pressure		
Pacemaker		
Heart Disease		
Dizziness/Fainting		
Fevers/Chills		
Weight Changes		
Pelvic Organ Prolapse		
Endometriosis		
Cysts/ Fibroids		
Urinary Tract Infections		

Surgeries:	Date:
Hysterectomy	
C-Section	
Gall Bladder	
Prostatectomy	
Appendectomy	
Hernia repair	
Laparoscopy	
Metoidioplasty	
Phalloplasty	
Vaginoplasty	
Mastectomy	
Gender Affirmation Surgery	
Chest reconstruction	
Other:	

Please list ALL medication/supplements (prescription or over-the-counter) you currently take:

_____

_____

Do you have any allergies? _____

_____

If Applicable:

Have your periods stopped? Yes / No Date of last period: _____

Do you have an IUD? Yes / No Do/did you have pain with your periods? Yes / No

Are you pregnant? Yes / No Are you attempting to get pregnant? Yes / No

How many times have you been pregnant: _____

How many times have you given birth: _____ Vaginal or C-section

Did you have a tear or episiotomy or assisted birth? _____

Are you on any type of supplemental hormone therapy? Yes / No (If so, please list:_____)

restore
PHYSICAL THERAPY

BLADDER HEALTH INTAKE

If you have no concerns with your bladder, please skip this section	Never	Sometimes	Often	N/A
Do you leak urine when you cough, sneeze, laugh, or when lifting?				
Do you ever have an uncomfortable, strong need to urinate that if you don't reach the toilet you will leak?				
If "yes" to question #2, do you ever leak before you reach the toilet?				
Do you have an urge to urinate when you hear running water?				
Do you have an urge to urinate when your hands are in water?				
Do you ever leak urine during or after sexual intercourse?				
Have you had bladder, urinary or kidney infections?				
Are you troubled by pain or discomfort when you urinate?				
Have you had blood in your urine?				
Do you find it hard to begin to urinate?				
Do you have a slow urine stream?				
Do you strain to pass your urine?				
After you urinate, do you have dribbling or a feeling that your bladder is still full?				
Do you have burning when you urinate?				

Please try to give actual numbers for the following questions:

How many times do you urinate during the day? _____

How many times do you urinate after you go to bed? _____

How often do you leak urine? _____

Do you wear protection? **(Circle one):** None Pantiliner Maxi Pad Diaper/Serenity

How many pads do you use in a day? _____

Leakage equals **(Circle one):** Small (less than 1/2 cup) Large (more than 1/2 cup)

How much warning time do you have to get to the toilet? Seconds or Minutes _____

Fluid Intake: (Includes water and other beverages):

8 oz glasses per day (circle one below): *9+* *6 - 8* *3 - 5* *1 - 2*

Caffeinated drinks per day (circle one): *9 +* *6 - 8* *3 - 5* *1 - 2*

Type of caffeinated beverage(s): _____

restore
PHYSICAL THERAPY

SEXUAL HEALTH INTAKE

Are you currently sexually active? Yes No

Do you experience pain or other problems with sexual activity? Yes No

If yes, please describe: (e.g., pain with initial penetration, painful to touch, pain with thrusting)

_____
_____
_____
_____
_____

Do you have increased pelvic pain with other activities? Yes No
If yes, please describe: (e.g., wearing tight clothes, sitting, pain with gynecology exam)

_____
_____
_____
_____
_____

Does the pelvic pain ever feel like it travels? _____
If yes please describe: _____
_____
_____
_____

BOWEL HEALTH INTAKE

Even if you are not having bowel complaints, please fill out the following section as bowel health can relate to bladder or sexual health complaints

Frequency of bowel movements: (Circle one)

2+ times per day 1 time per day Every other day Once every 4-6 days Weekly

Do you strain to pass your bowels? Yes / No / Sometimes

Do you have pain with bowel movements? Yes / No / Sometimes

Do you have anal fissures? Yes / No

Do you have hemorrhoids? Yes / No Do you currently have hemorrhoids? Yes / No

Do you have fecal urgency? Yes / No / Sometimes

Do you have fecal incontinence? Yes / No

Do you still feel full after having a bowel movement? Yes / No

Do you ever have to use your hands to help pass a bowel movement? Yes / No

Do you use enemas? Yes / No If yes, when was the last time you used one _____

Do you take fiber supplements? Yes / No
If yes, please let us know which ones you use: _____

_____
_____

restore
PHYSICAL THERAPY

Payment Policy

Private Insurance: We will verify your insurance benefits as a courtesy to you. While we will take all reasonable action to provide accurate therapy benefit information for your specific plan, be aware that verification of benefits is not a guarantee of payment from your insurance carrier(s). Insurance companies will not guarantee payment until claims are processed. Please provide the most current insurance cards. We will bill your primary and/or secondary insurance. All co-pays, co-insurance, deductibles, and outstanding balances are due upon arrival. Any remaining balance after insurance(s) has processed is due from you upon receipt of the explanation of benefits from your insurance company (companies).

Medicare: Please provide the most current Medicare and insurance cards. We will bill Medicare and your secondary insurance (if you have one) for you. In most cases Medicare will pay 80% of the allowable charges after deductible. If you do not have a secondary insurance the balance will be billed to you. Please be advised the not all secondary insurance plans cover the deductible and co-insurance amounts. All co-pays, co-insurance, deductibles, and outstanding balances are due upon arrival. Any remaining balance after insurances has processed is due from you upon receipt of the explanation of benefits from your insurance company (companies).

Medicaid: Please provide current Medicaid card **and** Photo Identification prior to being seen. We will verify your eligibility. Claims could be denied if you are not eligible at the time of service. If you have a cost share, it is due at the time of service.

Self-Pay: Payment for self-pay is due at the time of service. Credit cards are accepted for payment on accounts. These services cannot be billed to any insurance company. In the event you are unable to pay the balance in full, we may be able to make a reasonable payment agreement. Please be advised that Restore Physical Therapy is not a credit guarantor, and therefore, failure to maintain these arrangements may result in the placement of your account with an outside collection agency.

Worker's Compensation: We will bill Worker's Compensation carrier for all charges. In the event that claims get denied for any reason you will remain financially responsible for all charges accrued during treatment. We can bill your private insurance for these services, if so all co-pays, co-insurance, deductibles, and outstanding balances are due upon arrival.

Motor Vehicle Insurance: We will bill your insurance policy as a courtesy to you. Restore Physical Therapy does not bill 3rd party or hold balances until the settlement. A signed lien will be required. If your policy does not have Med Pay available, we can bill your personal insurance, if so all co-pays, co-insurance, deductibles, and outstanding balances are due upon arrival. Please be advised that you will be responsible if your carrier denies the charges. Restore Physical Therapy is not a credit guarantor, and therefore, failure to maintain these arrangements may result in the placement of your account with an outside collection agency. Credit cards are accepted for payment on accounts.

_____ _____

Patient or Guardian Signature **Date**