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10705 Charter Drive, Suite 420, Columbia, MD, 21044, (443)-283-2018

Patient Registration Form

First Name: _____ Last Name: _____ MI: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Height: _____ Weight: _____ Occupation: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____ E-mail Address: _____

Phone #1: _____h/w/c Phone #2: _____h/w/c

Emergency Contact: _____ Phone: _____ Relationship: _____

Family Physician: _____ Location (City, State):_____

Referring Physician: _____ Location (City, State):_____

How would you prefer to receive appointment reminders?
□ Email
□ Phone call
□ Text message

Would you please tell us how you found our office?
□ Doctor Referral
□ Other: _____

INSURANCE INFORMATION:

PRIMARY Insurance Company**:** _____

Member ID: _____ Name/DOB of insured person: _____

Insurance Co. Address: _____ Phone: _____

SECONDARY Insurance Company: _____

Member ID: _____ Name/DOB of insured person: _____

Insurance Co. Address: _____ Phone: _____

Condition and Consent for Evaluation and Treatment of Pelvic Floor Dysfunction

Consent:
I acknowledge and understand that I have been referred to Her Health Physical Therapy, LLC 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, and vulva 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 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. The evaluation may include vaginal or rectal sensors for muscle biofeedback. I understand that this evaluation and/or treatment could potentially elicit pain or discomfort. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

Your physical therapist is female. No chaperone will be provided during your physical therapy evaluation and treatment sessions unless you request a chaperone to be present. You may choose to bring a friend or family member during the physical therapy evaluation or treatment at any time.

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 no guarantees have been or can be provided regarding the success of therapy. 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 by the therapists and therapy assistants and technicians of Her Health Physical Therapy, LLC.

Conditions:
In order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of $40.

Date_____ Patient Name: _____
(Please Print)

_____ _____
Patient Signature Signature of Parent or Guardian (If applicable)

Assignment of Benefits

By signing below you are verifying your consent to allow your insurance carrier to make payments directly to Her Health Physical Therapy at 10705 Charter Drive, Suite 420, Columbia, MD 21044 for all services rendered at the same location. You are also confirming that you have are aware that the verification of benefits is not a guarantee of payment by your insurance carrier and any claims unpaid by your insurance **become your responsibility.**

_____ _____
Patient Name (Please Print) Date

_____ _____
Patient Signature Signature of Guardian (if applicable)

Her Health
Physical·Therapy

Authorization for Use, Disclosure or Release of Protected Health Information and/or Medical Records

CHECK HERE if you DO NOT want your information shared with anyone at this time. → → → ☐

I hereby grant and authorize the use, disclosure, and/or release of information related to my physical therapy, medical information, and/or billing account to the following individual(s):

_____
_____
_____

Unless the following "No" box is marked, this Authorization extends to such psychiatric, mental health, and drug and alcohol abuse treatment information, if any, as may be contained in said medical record including information protected by I.C. 16-39-1-9, I.C. 16-39-2-1 through 16-39-4-2 and I.C. 16-41-8-1. This release permits re-disclosure in accordance with 42 C.F.R., Part 2, which is a federal regulation governing release and use of medical information pertaining to treatment for alcohol and drug abuse. ☐ **NO**

Unless the following "No" box is marked, the Authorization also extends to information regarding communicable diseases, including human immunodeficiency virus (HIV), and AIDS related complex (ARC) and acquired immunodeficiency syndrome (AIDS), if contained in said medical record. ☐ **NO**

I understand that upon release and disclosure of the protected medical records and information, the records and information may by subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

I understand that Her Health Physical Therapy will not deny treatment or eligibility for benefits based upon whether I sign this authorization. I also understand that an authorization may be necessary in order to process any request I have made for a release of medical records or other medical information. I may inspect or copy any information used or disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by mailing or delivering a written revocation to Her Health Physical Therapy. The revocation will be effective upon receipt by Her Health Physical Therapy, except to the extent that Her Health Physical Therapy has taken action in reliance on this authorization. I further understand that this authorization will expire sixty (60) days from the Signature Date for all records unless I specify a different expiration date or event here: _____.

I understand that there may be a charge to cover actual costs incurred by Her Health Physical Therapy up to $15.00 in preparing and delivering the information requested in this authorization, in accordance with Maryland statutes and Her Health Physical Therapy policies.

Print name: _____ **Date**: _____

Signature: _____

Signed if legal representative: _____ **Date**: _____

Relationship to the patient: _____**Printed name**: _____

HIPAA Notification: ***Health Insurance Portability and Accountability Act***

Notice of Privacy Practices

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this notice, please contact the Privacy Officer at this practice. If you would like detailed information regarding how we may use and disclose medical information about you and your individual rights regarding your medical information, please let us know and you will be provided with a copy of our Privacy Practices.

Patient Statement

I am aware that this practice, as required by law, maintains the privacy of protected health information as prescribed by HIPAA and that I have access to its provisions. I have been provided an opportunity to review the Notice of Privacy Practices. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in the Notice. I may revoke this authorization at any time in writing.

Signature: _____

Her Health
Physical·Therapy

Medical History Questionnaire

Your body and experiences are special and unique! Please complete the following questionnaire in order to give your physical therapist the most accurate and complete description of your medical history. By doing this you are allowing the therapist to know more about your body and what it's been through so she can provide you with the evaluation and treatment plan that is best for you.

Please Check	N/A	Family	Patient	Current vs Old	Explain
High Blood Pressure				C / O	
Heart Attack				C / O	
Heart Conditions				C / O	
Diabetes				C / O	
Cancer				C / O	
Stroke(s)				C / O	
Circulation Problems				C / O	
Epilepsy (seizures)				C / O	
Kidney Problems				C / O	
Asthma				C / O	
Thyroid Conditions				C / O	
Depression				C / O	
Anemia				C / O	
PMS				C / O	
Osteo-Arthritis				C / O	
STD				C / O	
Dizzy Spells				C / O	
Headaches				C / O	
Pacemaker				C / O	
Rheumatoid Arthritis				C / O	
Metal Implants				C / O	
Multiple Sclerosis				C / O	
Hepatitis				C / O	
Swelling				C / O	
Fibromyalgia				C / O	
Chemical Dependency				C / O	
Other:_____				C / O	

Your Exercise Level (please circle): Non-active 1 2 3 4 5 6 7 8 9 10 High Type: _____

Do you Smoke? Y / N If yes, how many packs per day? _____

List any significant injuries and/or physical therapy you have had in the past (include dates):

_____

What is the primary problem you would like your physical therapist to address?

_____

What was the Date of Onset/Injury for your current problem? _____

Write out your goal(s) for physical therapy:

_____

_____

If you are here for issues specifically related to Women's Health please also complete the following questions:

OB:

Are you Pregnant? Y N If yes, when was your last Ob-gyn visit? _____

Number of Pregnancies: _____Vaginal Deliveries: _____ C-Sections: _____ DandC: _____ Miscarriages: _____ Abortions: ____

Longest Length of pushing: _____ Number of episiotomies: _____ Number of tears: _____

Do you have a painful episiotomy scar? Y N Do you have a painful C-section scar? Y N

GYN:

Do you experience menstrual pain? Y N Have you experienced menopause? Y N

Do you have endometriosis? Y N If yes, approximate date of onset? _____

Have you been on hormone replacement therapy? Y N If yes, what type? _____

Urology:

Do you have a history of frequent UTI? Y N Do you have a history of urine loss as a child? Y N

Do you have a history of urine loss as an adolescent? Y N Do you have a history of urine loss during pregnancy or after childbirth? Y N

Do you have Interstitial Cystitis? Y N Do you have IBS? Y N

Current Medications:

*Please note that your physical therapist will ask about any changes in medication upon every visit secondary to insurance requirements. If you have additional medications/procedures, please include them on a separate page.

Medication: _____ Dosage: _____ Start date: _____ Reason: _____

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Medication: _____ Dosage: _____ Start date: _____ Reason: _____

Medication: _____ Dosage: _____ Start date: _____ Reason: _____

Medication: _____ Dosage: _____ Start date: _____ Reason: _____

Medication: _____ Dosage: _____ Start date: _____ Reason: _____

Procedures/Tests/Imaging:

(Example) Laparoscopic removal of uterine fibroids _____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

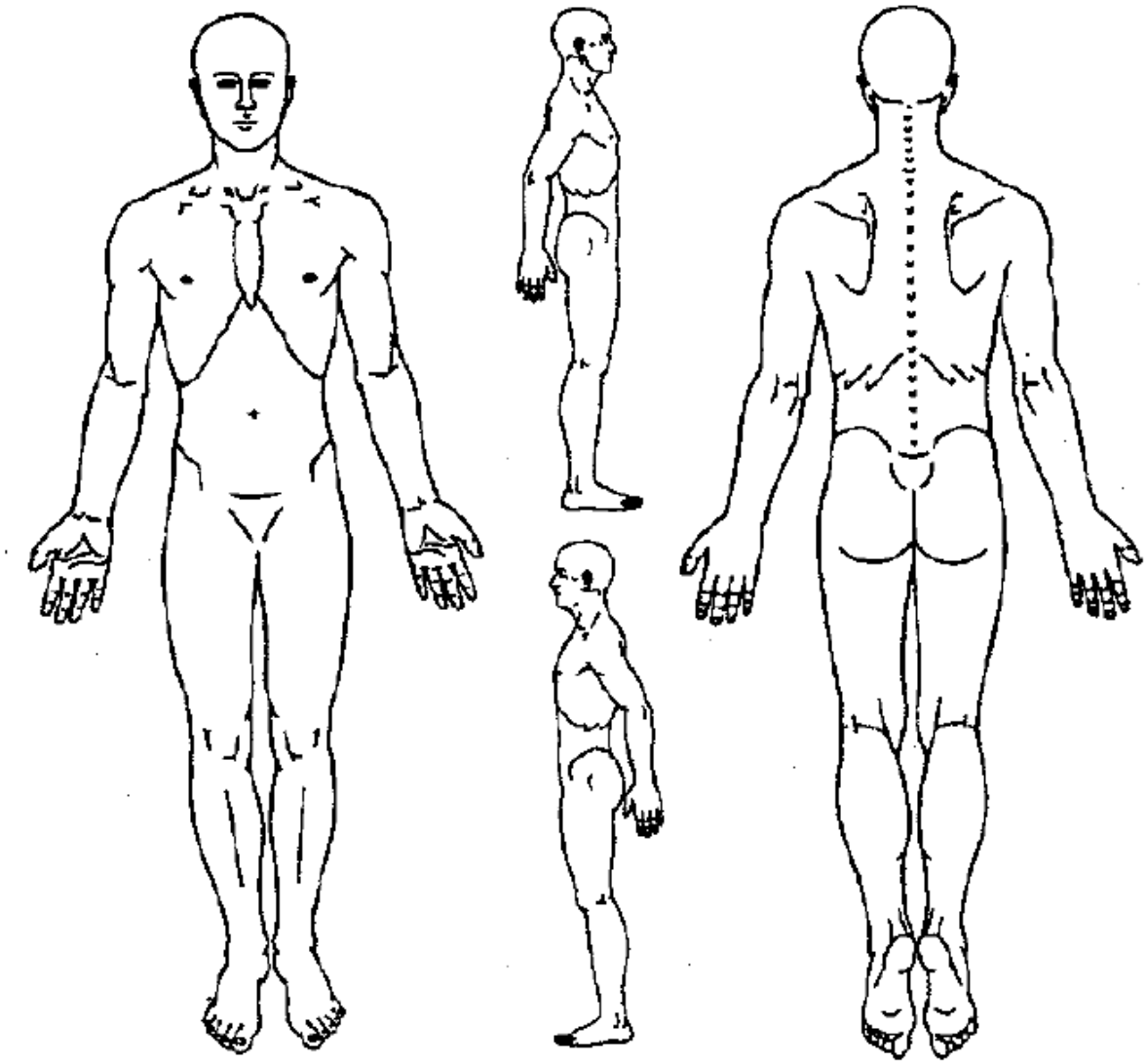
If you are experiencing pain, please complete this diagram. Thank You.

Name:_____ Date:_____

PAIN DIAGRAM

On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

Key: **A** – ACHE **B** – BURNING **N** – NUMBNESS
P – PINS & NEEDLES **S** – STABBING **O** - OTHER



PAIN SCALE

Rate the severity of your pain by checking one box on the following scale.

No Pain										Worst Possible Pain
0	1	2	3	4	5	6	7	8	9	10

Her Health Physical Therapy

Financial Policy:

We are pleased that you have selected our office to address your women's health and orthopedic physical therapy needs. As part of that care, we have developed this statement of our financial policy. Please ***carefully read*** the following and then ***initial*** in the space provided near each paragraph, and then sign below.

1) ____ **Health Insurance Participation**: Her Health Physical Therapy participates with many, but not all health insurance plans. If we do participate with your health insurance plan, you must present a valid insurance identification card at check-in. Without a valid insurance card, or if we do not participate in your health insurance plan, you will need to speak with the office manager or owner prior to treatment.
2) ____ **Co-Payments/Co-insurance**: Some insurance plans require payment of a Co-pay or Co-insurance. Payments are due at check-in or check-out. Payments may be made by check, cash, MasterCard or VISA.
3) ____ **Referrals**: Some insurance plans require a written referral from a primary care provider. Referrals must be presented at check-in. Having a valid referral is a ***patient's responsibility***. It is your responsibility to know how many visits are allowed on your referral and the expiration date of your referral. Without a valid referral if you need one for your insurance, you may reschedule your appointment *or* payment for your visit will be due upon treatment.
4) ____ **Financial Responsibility**: Patients are responsible for all co-payments, deductibles, and charges not covered by health insurance.
5) ____ **Deductibles**: If you have a large deductible ($500/contract year or more) that has not yet been met, you will pay **$40.00** per visit up front until you receive your Explanation of Benefits (EOB) from your insurance company. Once your EOB has been sent and the exact amount due is learned, you will be responsible for the remainder of your deductible (if any) at that time. If you have overpaid on your deductible, you will be reimbursed within 7 to 14 days of HHPT receiving your EOB from your insurance company.
6) ____ **Account Balances**: All outstanding balances must be paid at time of check-in, or if you need, you may set up a payment plan with the office manager or owner. Failure to pay outstanding balances in a timely manner may result in the practice forwarding your account to a Collection Agency or Collection Attorney of our choice and may result in additional fees, including an administrative fee of 30%. Again, you may set up a payment plan with the owner, and this will be set up on an individual basis. You will be given plenty of fair notice prior to any balance being sent to a Collection Agency.

******When you do not keep your scheduled appointment, 3 people are hurt:******

1. ***YOU*** *– because you are not getting the treatment you need*
2. ***THE THERAPIST*** *– Who has an open space in the schedule which was reserved exclusively for you.*
3. ***ANOTHER PATIENT*** *– That could have been scheduled if you would have given our office proper notice.*

******The fourth is this practice, one of the few remaining clinics that treat women's health and still accepts insurance!******

7) ____ **Cancellation**: Any cancellation made over the weekend or on a holiday for the very next business day will be subject to a $**40.00** cancellation fee.
8) ____ **Cancellation/No-Show**: You must cancel any appointment with a full 24 hour business days notice on the telephone or you are subject to a **$40.00** cancellation/No-Show fee. We cannot accept cancellations via e-mail.
9) ____ **Late Fee:** You will be given three visits where you can run late. If you continue to arrive greater than 7 minutes late to your appointments, you will be billed a **$20.00** fee after this every time you run late. Your physical therapist has to bill your insurance per unit of time they spend with you. They cannot bill you for a full treatment unless they see you at least 53 minutes. If they do not consistently see you for the full hour as scheduled, the company cannot afford to keep this specialist employed.

I (the client of Her Health Physical Therapy) have read and understand the office policies explained above:

Print name: _____ **Date**: _____

Signature: _____

OFFICE USE ONLY – DO NOT SIGN:
Therapist who reviewed financial policy with this client: (Print Name): _____

Signature: _____ Date: _____