10705 Charter Drive, Suite 420, Columbia, MD, 21044
306 S. Main Street, Mt. Airy, MD, 21771
FrontDesk@HerHealthPT.com
(443)-283-2018

Patient Registration Form

First Name: ______________________________ Last Name: ___________________________ MI: _________

Preferred Name:__________________________ Preferred Pronoun (ie. he/him, she/her, them/they): _________________

Date of Birth: _____________________ Age: ________ Marital Status: __________________________

Height: _________ Weight: _________ Occupation: ____

Street Address: ____

City: ____ State: ____________ Zip Code: _______________

E-mail: _____________________________________ I consent to receive email communication (including invoices): ____ (Initial)

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 (Important details regarding scheduling included)

□ Phone call

□ Text message

Would you please tell us how you found our office?

□ Doctor Referral

□ Other: _________________________________

* Email reminders will be sent 1-2 days prior to your scheduled appointments, and phone call/text reminders will be sent the night before your scheduled appointment. **Appointment reminders are only a courtesy. It is the patient's responsibility to keep all scheduled appointments and to arrive on time.**

PRIMARY Insurance Company**:** ____

Member ID: _________________________________ Name/DOB of insured person: ______________________________

Insurance Co. Address and/or Phone#: ____

SECONDARY Insurance Company: ____

Member ID: _________________________________ Name/DOB of insured person: ______________________________

Insurance Co. Address and/or Phone#: ____

Conditions & Consent for Outpatient Treatment

Cooperation with Treatment:
I understand that in order for therapy to be effective, I must come to my physical therapy appointments as scheduled unless there are unusual circumstances that prevent me from attending.
I understand that I may be discharged from physical therapy if I do not keep three (3) appointments without calling to cancel.
I agree to cooperate with the home program assigned to me. If I have difficulties, I will discuss them with my therapist.

No Warranty:
Her Health Physical Therapy does not promise a cure for my condition. They will share with me the available statistics and studies regarding results of physical therapy treatment for my condition. They will discuss all treatment options with me.

Informed Consent to Treatment:
The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. The department provides a wide scope of services and you will receive information at the initial visit on the treatment/assessment options available for your condition.

Potential Risks:
You may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury. This discomfort is temporary and will probably subside in 24 hours.

Potential Benefits:
These include an improvement in your symptoms and an increase in your ability to perform your daily activities. You may experience increased strength, awareness, flexibility, and endurance in your movements. You may experience decreased pain. You will have greater knowledge on managing your condition and the resources available to you.

Alternatives:
All physical therapy treatment options available for your condition will be explained to you. You may inquire on the cost of these services and discuss them with your therapist. If you do not wish to participate in the program created for you by your physical therapist, you may discuss your medical, surgical, or pharmacological alternatives with your physician.

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.

Based on the above information, I voluntarily consent to physical therapy treatment. I understand that I may withdraw at any time.

___________________________________ _________________
Patient Name (Please Print) Date

___________________________________ _______________________________
Patient Signature Signature of 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)

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 surgery or childbirth, persistent sacroiliac or low back pain, and vulvovaginal or penile/prostate 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/penis 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 pelvic 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. Your physical therapist may also choose to bring a chaperone into session.

Treatment may include, but not be limited to the following: observation, palpation, use of internal weights, 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 also understand that treatments may be triggering for those who have had any form of sexual or surgical trauma.*** 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 that I may be discharged from physical therapy if I do not keep three (3) appointments without calling to cancel. 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.

__________________________________ ________________
Patient Name (Please Print) Date

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__________________________________ ________________
Patient Name (Please Print) Date

__________________________________ ______________________________
Patient Signature Signature of Guardian (if applicable)

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

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):

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

____

(Doctor, Hospital, Attorney, Self, etc.) (Phone/Fax Number)

____

(Doctor, Hospital, Attorney, Self, etc.) (Phone/Fax Number)

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.

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.

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.
If you do not wish for the above information be shared, please make the office aware.

____

Patient Name (Please Print)

____ __________________

Patient Signature Date

____ __________________

Name and Signature (if legal representative/guardian) Date

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.

Patient Signature: ____ Date: ______________

Medical History Questionnaire

Name: ________________________

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.

Our physical therapists and staff support the American Medical Association's nondiscrimination policy, in that: This office appreciates the diversity of human beings and does not discriminate based on race, age, religion, ability, marital status, sexual orientation, sex, or identity.

	N/A ✓	Family ✓	Patient ✓	Current vs Old	Explain
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	
Other:_____________				C / O	

Her Health Physical-Therapy **Medical History Questionnaire, Continued** **Name:** ______________________________

GENERAL/ SOCIAL:

Your Exercise Level (circle): Non-active 1 2 3 4 5 6 7 8 9 10 | Type of exercise: ____________________

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? ____ | Date of onset/injury for your current problem? ______________

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

Date of onset/injury for your current problem? ____

Write out your goal(s) for physical therapy: ____
____
____

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

Are you currently sexually active? ☐Yes ☐No ☐Decline to answer | What sex were you assigned at birth?: ☐M ☐ F ☐ Decline to answer

What is your current gender identity? (Check all that apply):	Do you think of yourself as:
☐ Male ☐ Female ☐ Genderqueer	☐ Straight/heterosexual
☐ Transgender Female/Trans Women/MTF	☐ Lesbian/Gay/Homosexual
☐ Transgender Male/Trans Man/FTM	☐ Bisexual
☐ Additional (please specify) __________________	☐ Additional (please specify) ________________
☐ Decline to answer	☐ Decline to answer

IF YOU ARE HERE FOR ISSUES RELATED TO **VULVOVAGINAL** HEALTH, PLEASE ALSO COMPLETE THE FOLLOWING QUESTIONS

OB:

Are you pregnant? ☐ Yes ☐ No | If yes, when was your last ob-gyn visit? ______________________________

# of:	Pregnancies: ______	Vaginal Deliveries: _____	C-Sections: ____	D&C: ______	Miscarriages: _____	Abortions: ______

Longest length of pushing: ______________ | Number of episiotomies: ____________________ | Number of Tears: ______________

Do you have a painful episiotomy scar? ☐ Yes ☐ No | Do you have a painful c-section scar? ☐ Yes ☐ No

GYN:

Do you experience menstrual pain? ☐ Yes ☐ No | Do you have endometriosis? ☐ Yes ☐ No

Have you experienced menopause? ☐ Yes ☐ No ---------- If yes, approximate date of onset? ____________________

Have you been on hormone replacement therapy? ☐ Yes ☐ No ---------- If yes, which type? ____________________

Do you have a history of urine loss:

- As a child? ☐ Yes ☐ No
- As an adolescent? ☐ Yes ☐ No
- During pregnancy/after childbirth? ☐ Yes ☐ No

Do you have a history of frequent UTI? ☐ Yes ☐ No

Do you have Interstitial Cystitis? ☐ Yes ☐ No

Do you have IBS? ☐ Yes ☐ No

IF YOU ARE HERE FOR ISSUES RELATED TO **PENILE/PROSTATE HEALTH,** PLEASE ALSO COMPLETE THE FOLLOWING QUESTIONS:

Sexual Function:

Do you have trouble maintaining a firm (hard) erection? ☐ Yes ☐ No | Can you achieve an orgasm? ☐ Yes ☐ No | Can you ejaculate normally? ☐ Yes ☐ No

Do you have trouble maintaining a firm (hard) erection to completion of intercourse (i.e. Do you lose your erection too quickly)? ☐ Yes ☐ No

Do you experience pain with erections? ☐ Yes ☐ No | Do you experience pain with orgasm? ☐ Yes ☐ No

Prostate:

Have you ever been treated for prostate cancer? ☐ Yes ☐ No | Have you had surgery for prostate cancer? ☐ Yes ☐ No | Have you had radiation for prostate cancer? ☐ Yes ☐ No

Have you had surgery for benign prostate enlargement? ☐ Yes ☐ No | Are you on androgen deprivation therapy for prostate cancer? ☐ Yes ☐ No

Urology:

Do you have a history of frequent UTI? ☐ Yes ☐ No | Do you have Interstitial Cystitis (Painful Bladder Syndrome)? ☐ Yes ☐ No

Do you have a history of urine loss as a child? ☐ Yes ☐ No | Do you have a history of urine loss as an adolescent? ☐ Yes ☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers. *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/Frequency**	**Start Date**	**Reason**

Surgeries/Procedures/Tests/Imaging	
Date	*(Example) Laparoscopic removal of uterine fibroids*

If you are experiencing pain, please complete the diagram below:

Pain Diagram

On the diagrams to the right, mark where you are experiencing pain.

Use the letters provided in the key below to indicate the type and location of your sensations.

Key:	**A** – Ache	**B** – Burning	**N** – Numbness
P – Pins & Needles	**S** – Stabbing	**O** - Other	

Please 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 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, credit, or debit card.
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 the ***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 required valid referral, 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 insurance.
5) **Deductibles**: If you have a large deductible (< $500/contract year) 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.
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 pelvic health and still accepts insurance!*****

7) **Appointments Reminders:** You may opt-in to receive appointment reminders via phone call, text message, email, or a combination of the three options. These reminders will be sent 1-2 days prior to your scheduled appointments.
*** Appointment reminders are only a courtesy. It is the patient's responsibility to keep all scheduled appointments and to arrive on time.**
8) **Termination of care**: Her Health Physical Therapy reserves the right to terminate care at any time. In the event that care is terminated, HHPT will provide you with the name of another health care provider capable of handling your care.
9) **Cancellation/No-Show**: You must cancel any appointment with a full **24 hour business days notice**, or you are subject to a **$40.00** cancellation/no-show fee. **There are no exceptions.** You may leave a voicemail; however, **we cannot accept cancellations via e-mail.**
10) **Late/Early Departure Fee:** You will be given three visits where you can run late or depart early. You will be billed a **$20.00** fee for each consecutive time you continue to arrive 7 minutes late to or leave 7 minutes early from your appointments. Your physical therapist has to bill your insurance per unit of time they spend with you. ***They cannot bill 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: Staff member who reviewed financial policy with this client: **(Initials)**: ________________ **Date**: ________________