405 E Marshall | Gilmer, TX 75644 | OFFICE: 903-402-1052 | FAX: 888-335-2090

625 Chase Dr. Suite 105 | Tyler, TX 75701 | OFFICE: 903-717-8966 | FAX: 903-630-1893

PATIENT NAME: FIRST_____MIDDLE_____LAST_____ SEX: [ ] M OR [ ] F

DATE OF BIRTH: _____ MARITAL STATUS: [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] WIDOWED

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME #: _____ CELL #: _____ SOCIAL SECURITY NUMBER: _____

EMAIL ADDRESS: _____ EMPLOYER NAME & PHONE:_____

REFERRING PHYSICIAN: _____ PRIMARY PHYSICIAN: _____

WHO MAY WE CALL IN CASE OF AN EMERGENCY: _____ PHONE: _____

HOW DID YOU HEAR ABOUT US? _____

ARE YOU CURRENTLY ENROLLED IN **HOME HEALTH** OR HAVE YOU BEEN IN THE LAST 30 DAYS? [ ] **YES** [ ] **NO**

Pelvic Floor Consent for Treatment and Attendance Agreement

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunction includes, but is not limited to urinary or fecal incontinence, difficulty with bowel, bladder or sexual function, painful scars after childbirth or surgery, sacroiliac disorders, low back pain, or pelvic pain.

I understand that to evaluate my condition, it may be necessary, initially or periodically, to have my therapist perform an internal pelvic floor exam. This is performed by observing and/or palpating digitally externally or internally the vagina or rectum and/or surrounding areas of the pelvic floor. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

Treatments may include the following: observation, palpation, use of vaginal/rectal sensors, heat, cold, stretching, strengthening exercises, soft tissue massage or mobilization, and educational instructions.

I understand and agree that 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. I understand that if I do not show 2 appointments, I will be discharged from therapy services for non-compliance.

1. The purpose, risks, and benefits of pelvic floor physical therapy have been explained to me.
2. I understand that I can terminate the procedure at any time.
3. **I understand that if I can not make my scheduled appointments, I will notify The Pelvic Fixx within 24 hours of my appt time**.

Patient Signature: _____ Staff Initials: _____ Date: _____

PATIENT FINANCIAL RESPONSIBILITY AND CONSENT TO TREAT

INSURANCE

- I, _____, consent to physical therapy services performed by the staff of Kinetic Physical Therapy Associates as well as allowing them to bill my primary and/or secondary insurance(s) for services rendered. Once billed, I authorize my health insurance provider to make direct payment(s) to Kinetic Physical Therapy Associates. After verification of insurance benefits, the estimated amount I will be responsible for is $_____ due prior to or immediately after each daily visit. Any remaining balances will be due at the date of discharge.

OR

CASH PAY

- I, _____, consent to physical therapy services performed by the staff of Kinetic Physical Therapy Associates and am forgoing the use of health insurance, therefore will be paying $_____ out of pocket each visit, due at the conclusion of treatment. Any remaining balance will be due at the date of discharge.

Patient Signature: _____ Date: _____

Staff Signature: _____

HIPAA – Release of Information

Name: _____ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination performed, treatment rendered to me, appointment scheduling, and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is **NOT** to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

Contact by calling my:

[ ] Home: _____

[ ] Cell: _____

[ ] Work: _____

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (day)_____ between (time)_____

Legal Representative or Patient Signature: _____ Date: ____/____/_____

Name and Signature of Witness:_____ Date: ___/____/_____

PATIENT QUESTIONNAIRE: MALE PELVIC FLOOR

Name: _____ **Age:** _____ **DOB:** _____ **Weight:** _____**Height:**_____

Referring Doctor: _____ **Diagnosis:** _____

Have you received previous Physical Therapy for this problem? (circle) No OR Yes: (date):_____

Have you received other treatment for this problem? No OR Yes: (type)_____

Medical History (circle all that apply): heart problems / hypertension / diabetes / cancer / seizures thyroid dysfunction / hx of fractures / asthma / chronic bronchitis / lung disease / smoker / osteoarthritis rheumatoid arthritis / hx of stroke / kidney problems / depression / osteoporosis / hx of blood clots/DVTs Other:_____

Surgical History (list type & date): _____

_____

Pelvic History (fill in blanks or circle answer for all that apply):

History of Benign Prostatic Hyperplasia? No OR Yes: (specify date(s) and any treatments received)

_____

History of prostate cancer? No OR Yes: (specify date(s) and treatments) _____

_____

History of hemorrhoids or other colorectal problems? No OR Yes: (specify date(s) and treatments)

_____

History of sexually transmitted diseases: No OR Yes: (specify active infections)_____

History of chronic urinary / bladder infections? No OR Yes: (specify)_____

Current Medications: _____

Allergies: _____

Work Status: ☐ currently working ☐ retired ☐ temporarily off work ☐ unemployed ☐ other:

Location / type of work: _____

Emergency Contact:

Name: _____ Daytime phone #: (____)_____ -_____

How did you learn about us? ☐ friend ☐ physician ☐ internet ☐ advertisement ☐ other:

Date of your next doctor's appointment: _____

_____ _____

Patient's Signature **Date**

MALE PELVIC FLOOR REHAB: SYMPTOM QUESTIONNAIRE

Urinary Symptoms: Check all that apply and fill in appropriate blanks.

___ Urgency (experiencing unusually strong urges to urinate that may come on suddenly)
___ Frequency: urinate _____ times per (circle one) hour / day.
___ Leaking: When I leak, it (circle all that apply):
dampens underwear / dampens outerwear / empties my bladder completely.
___ Leaking: I leak with (circle all that apply): a strong urge to urinate / lifting / coughing laughing / sneezing / bending / standing up / opening door to house / parking car on way to bathroom / walking / jogging/exercise / hear running water / dribble after urination
other:_____
___ Leaking: I leak _____ times a (circle one): day / week.
___ Leaking: I cannot tell when I leak; sometimes it feels like I constantly leak.
___ Use of leakage protection (number per day): thin liner____ / pad____ / diaper_____
___ Wake at night to urinate: number of times each night: _____
___ Burning with urination
___ Abnormal stream (specify:_____)
___ Difficulty or hesitancy with emptying bladder

Other:_____

Fluid Intake: Fill in average number of cups (1 cup=8 ounces) of intake of each of the following per day:

___ Water ____ Milk ____ Juice (specify:_____)
___ Soft Drinks ____ Decaf Soft Drinks ____ Tea
___ Decaf Tea ____ Coffee ____ Decaf Coffee
___ Alcohol ____ Other:_____

Bowel Symptoms: Check all that apply and fill in blanks.

Number of bowel movements per (circle one) day / week : _____

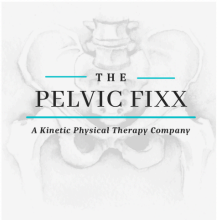
___ Constipation: Do you frequently strain to move bowels because of this? Yes OR No
___ Take regular fiber supplements (type and frequency):_____
___ Frequent diarrhea
___ Irritable bowel syndrome
___ Lactose intolerance or other food allergy affecting bowels (specify other: _____)
___ Bowel leakage (circle all that apply): stains underwear / small amount / large amount
I leak with lifting / coughing / laughing / sneezing / bending / standing up / walking / jogging/exercise / sexual intercourse / other:_____
___ Bowel leakage: I leak _____ times a (circle one) day / week.
___ Use of leakage protection (number per day): panty liner____ / pad____ / diaper_____

Other: _____

Pain Symptoms:

Do you have pain? No OR Yes: location:_____
Describe how the pain feels: _____
How long has pain occurred: _____
Are any of your normal activities limited by pain? No OR Yes: (specify)_____
What makes your pain worse?:_____
Better?: _____
Rate your pain on the following scale: 0=no pain at all, 5=moderate pain, 10=worst pain imaginable
At worst (circle one): 0 1 2 3 4 5 6 7 8 9 10 On average: 0 1 2 3 4 5 6 7 8 9 10

Goals you want to achieve through therapy (be specific): _____



CANCELLATION and NO SHOW POLICY

We have updated our Cancellation and No Show Policy. This will become effective on September 1, 2023.

By signing below, you authorize knowledge of this information and agree to comply with our policy.

Cancellation Policy:

I understand that a 24 hour notice **MUST** be given to The Pelvic Fixx either by email or phone. Calls received after 4 pm prior to the day before your appointment will not be answered until the next business day. Therefore, a voicemail must be left in order to comply with this policy. Cancellations less than 24 hours notice **will be charged a $40.00 fee** which will be collected prior to the next scheduled appointment.

No Show Policy:

I understand that if I No Show/No Call for my scheduled appointment, I will also be charged a **$40.00 fee**. **If I No Show/No Call 2 appointments, I give The Pelvic Fixx the authority to remove any future scheduled appointments and to discharge me from their care due to non-compliance of this policy.**

If you are more than 15 minutes late, The Pelvic Fixx reserves the right to refuse care due to limited availability and 1 hour time slots.

Your compliance with this policy only helps The Pelvic Fixx provide you with the best care possible in the most timely manner. Thank you for your understanding and we look forward to working with you!!!

_____ _____

Patient Name Date

_____ _____

Witness Date

Phone: Tyler - 903-717-8966 or Gilmer - 903-402-1052
Email: thepelvicfixx@gmail.com

Questionnaire for Urinary Incontinence

Do you leak urine (even small drops), wet yourself, or wet your pads or undergarments...	**NONE**	**Rarely**	**Once in Awhile**	**Often**	**Most of the time**	**All the Time**
1. when you **cough** or **sneeze**?	□	□	□	□	□	□
2. when you **bend down** or **lift something up**?	□	□	□	□	□	□
3. when you **walk quickly, jog** or **exercise**?	□	□	□	□	□	□
4. while you are **undressing** in order to use the **toilet**?	□	□	□	□	□	□
5. Do you get such a **strong and uncomfortable need** to urinate that you leak urine (even small drops) or wet yourself before reaching the toilet?	□	□	□	□	□	□
6. Do you have to **rush to the bathroom** because you get a **sudden, strong need** to urinate?	□	□	□	□	□	□