



3989 E Arapahoe Road, Suite 120  
Centennial, CO 80122  
303.740.2026 *phone, text*  
303.770.5459 *fax*  
www.ptspecialist.com

## New Patient Form

### PATIENT INFORMATION

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Name (Last, First, MI)

\_\_\_\_\_  
Nickname

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip code

\_\_\_\_\_  
Primary Phone

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Emergency Contact

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone

Sex:    ☐ M    ☐ F

**Please note: Minors must be accompanied by a parent/guardian for the first visit to sign consent forms in person**

### PARENT/GUARDIAN

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip code

\_\_\_\_\_  
Primary Phone

### PHYSICIAN INFORMATION

*In an effort to provide the highest quality health care for you, we would like to be able to communicate with your healthcare team. Please provide us with the names and phone numbers of any additional health practitioners involved in your care.*

\_\_\_\_\_  
Primary Care Physician

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Additional Healthcare Provider

\_\_\_\_\_  
Type of Care

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Additional Healthcare Provider

\_\_\_\_\_  
Type of Care

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Additional Healthcare Provider

\_\_\_\_\_  
Type of Care

\_\_\_\_\_  
Phone

Who can we thank for referring you to Physical Therapy Specialists? \_\_\_\_\_

Internet:   ☐ Google    ☐ Facebook    ☐ Yelp    ☐ Other: \_\_\_\_\_



\_\_\_\_\_  
(Initials) My insurance may reimburse me for services provided by Physical Therapy Specialists.

I authorize Physical Therapy Specialists to mail/fax copies of my payments and progress notes, if necessary, to my insurance company for reimbursement.



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## Physical Therapy Agreement of Policies

Please note that payment is made by the patient in full at the time of the appointment. Your insurance may offer benefits for out of network providers. As a courtesy, we can call to obtain your benefits for you. Just ask!

We are a non-participating provider for Medicare. Medicare subscribers also will pay at the time of service. We are still required to submit claims to Medicare and the reimbursements will be sent directly to you. Medicare will reimburse approximately 80% of the Medicare approved amount; your secondary insurance may also pay a portion according to the insurance plan details for physical therapy.

Fees are based on time spent with you and the treatments performed during your appointment. The fee ranges are as follows:

<b>Initial Evaluation</b>	<b>\$195</b>
<b>60 Minute Visits</b>	<b>\$170</b>
	<b>(a \$7.00 charge for disposable medical supplies may be added for dry needling and biofeedback)</b>

To maximize the enjoyment of your visit and in consideration of others, we ask you to carefully read and agree to the following policies:

### PHYSICAL THERAPY POLICIES

- o Please be ready for your appointment at the scheduled time, arriving early if needed to use the restroom, schedule additional appointments, etc. Appointments MUST end at the time scheduled and cannot be extended.
- o If you arrive late to your scheduled appointment, you will be billed for the allotted time scheduled.
- o Please report any health issues, even minor injuries to your PT before your session begins.
- o Cell phones and pagers should be silenced.
- o Children must be supervised and cannot interrupt the therapy session. This is to maximize your therapy time. If at all possible, make other arrangements for your child.
- o Physical Therapy Specialists is not responsible for lost or stolen property.
- o Physical Therapy Specialists has the right to cancel an appointment the day of service due to family emergency, weather or illness. The appointment will be rescheduled for the next available time slot.

I have fully read, understand, and agree to follow the above policies.



Print Name

Signed

Date



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## Conditions and Consent for Physical Therapy

### COOPERATION WITH TREATMENT

I understand that in order for physical therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. Late arrivals will be billed for the time scheduled. I agree to cooperate with and carry out the home physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

### NO WARRANTY

I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss all treatment options with me before I consent to treatment.

### INFORMED CONSENT FOR TREATMENT

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

- **Potential Risks:** I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.
- **Potential Benefits:** Benefits may include an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.
- **Alternatives:** If I do not wish to participate in the therapy program, I will discuss my medical, surgical, or pharmacological alternatives with my physician or primary care provider.
- **Release of Medical Records:** I authorize the release of my medical records to my physicians/primary care provider or insurance company.

### FINANCIAL AND INSURANCE RESPONSIBILITIES

I agree to pay for my treatments at the time of service, by cash, check or credit card unless other mutually agreed upon arrangements have been made. I understand it is my responsibility to call my insurance company ahead of time and obtain any pre-authorization that is necessary and get an estimate of my benefits. I understand that I will be provided with a paid receipt for services.

I understand that I am a patient of Physical Therapy Specialists, P.C., at 3989 E. Arapahoe Road, Suite 120, Centennial, CO, 80122. I agree to hold Physical Therapy Specialists harmless for any and all actions, causes of action claims, demands, damages, costs, loss of services, expenses, compensation, and all consequential damages and particularly on account of all injuries, both to my person and to my property, which have resulted or in the future may develop, or arise out of services and/or treatment. My care is the exclusive responsibility of Physical Therapy Specialists, P.C.

### TELEHEALTH

Some patients may be eligible for treatments performed via telehealth, video conferencing. We use the teleconferencing platform PT Everywhere, which is HIPPA compliant with end to end secure encryption. Options for telehealth treatment may be discussed with your physical therapist.

*I have read the above information and I consent to physical therapy evaluation and treatment.*

**Please be prepared to sign this consent for treatment at your first appointment.**



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## Cancellation and Missed Appointment Policy

Our goal is to provide quality, individualized physical therapy in a timely manner. “No-shows” and late cancellations inconvenience those individuals who need therapy. Following, is our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of treatment.

### CANCELLATION OF AN APPOINTMENT

In order to be respectful of the medical needs of other patients on our waiting list, please be courteous and call the office promptly if you are unable to attend a scheduled appointment. Your appointment time will be reallocated to another patient in need of treatment. Appointments are in high demand and your early cancellation will give another patient the opportunity to have access to that appointment time.

***If it is necessary to cancel your appointment, we require a call or text at least 48 hours in advance. Cancellations for Mondays must be received by the previous Friday by 5:00 pm. Two consecutive late cancellations or no-shows may warrant discharge from physical therapy.***

### HOW TO CANCEL AN APPOINTMENT

To cancel appointments please call or text **303-740-2026**. If you do not reach the office staff, you may leave a detailed message on voicemail. It is considered a late cancellation when a patient cancels their scheduled appointment without 48 hours advance notice.

***If we do not receive 48 hours' notice, you will be charged a \$75.00 fee the first time and the cost of your last appointment the second time. Two consecutive late cancellations may warrant discharge from physical therapy.***

### NO SHOW POLICY

A “no-show” is someone who misses a scheduled appointment without notice. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a “no-show”.

***For a “no-show” appointment, you will be charged a \$75.00 fee the first time and the cost of your last appointment the second time. Two consecutive no-shows may warrant discharge from physical therapy.***

### LATE ARRIVALS

In the event you are running late for your appointment, it is appreciated to call ahead to notify us of your expected late arrival. Please note that in order for us to accommodate other patients we will not be able to extend your appointment time and you will be charged the full amount for your visit.

Please take advantage of our Reminder Services. Appointment reminders can be delivered via text and email.

*Please note: Exceptions will be made on a case by case basis.*

I have read the policy above and agree to the terms.



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Signature

Print Name

Date

## Consent to Use and Disclosure of Health Information (HIPPA)

### CONSENT AND DISCLOSURE

#### PHYSICAL THERAPY SPECIALISTS

By signing this form, you are granting consent to Physical Therapy Specialists to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices Guide provides more detailed information about our legal obligations to protect your health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at 303-740-2026. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance of your consent.

By signing below, I acknowledge that Physical Therapy Specialists follows the "Notice of Health Information Privacy Practices" guideline as outlined in the Health Information Portability and Accountability Act (HIPPA).



Signed \_\_\_\_\_

Date \_\_\_\_\_

## Communication Consent

### COMMUNICATION

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's cell phone number instead of an individual's home phone number.

I wish to be contacted in the following manner (Check all that apply):

- ☐ Primary Phone: \_\_\_\_\_
  - ☐ OK to leave voicemail message with detail information
  - ☐ OK to leave message with a family member
  - ☐ Leave message with call back number only
- ☐ Secondary Phone: \_\_\_\_\_
  - ☐ OK to leave voicemail message with detailed information
  - ☐ OK to leave message with a family member
  - ☐ Leave message with call back number only

Written Communication:

- ☐ OK to email at this address: \_\_\_\_\_
- ☐ OK to mail to my home address



**My preferred method of contact for appointment reminders is:**

☐ Text

☐ Email



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## How to Determine Your Insurance Benefits for Physical Therapy

KEEP THIS WORKSHEET FOR YOUR RECORDS

1. Call the 1-800 # for customer service on your insurance card. Select the option that will allow you to speak with a customer service provider, not an automated system.
2. Ask the customer service provider to quote your physical therapy benefits in general. These are frequently termed rehab benefits and can include occupational therapy, speech therapy and sometimes massage therapy.
3. Make sure the customer service provider understands you are seeing a non-preferred provider/out-of-network provider.

### WHAT YOU NEED TO KNOW

- ✓ Do you have an OUT-OF-NETWORK deductible? \_\_\_\_\_  
If so, how much is it? \_\_\_\_\_
- ✓ How much of the deductible has already been met? \_\_\_\_\_
- ✓ What percentage of reimbursement do you have after the deductible is met? (60%, 80%, 90%, are all common)  
\_\_\_\_\_
- ✓ Does your policy require a written prescription from your primary care physician? \_\_\_\_\_
- ✓ Does your policy require pre-authorization or a referral on file for outpatient physical therapy services?  
\_\_\_\_\_
- ✓ How many physical therapy visits are allowed per year? \_\_\_\_\_
- ✓ Is the plan based on a calendar year?  
\_\_\_\_\_
- ✓ If not, what are the plan dates? \_\_\_\_\_

### WHAT THIS INFORMATION MEANS:

- A deductible must be satisfied before the insurance company will pay for therapy treatment. We can provide forms and receipts for you to mail to your insurance company to help reach the deductible amount.
- If you have an office visit co-pay the insurance company will subtract that amount from the percentage they will pay. This will affect the amount of reimbursement you will receive.
- The reimbursement percentage will be based on your insurance company's established "reasonable and customary/fair price" for the service codes rendered. This price will not necessarily match the charges billed. Some may be less than you have paid.
- If your policy requires a prescription from your PCP, you must obtain one to send in with the claim. This is usually not difficult to obtain since your PCP sent you to a specialist for help with your condition. If the prescription from a MD or specialist is all you need, make sure to have a copy to include with your claim. Each time you receive an updated prescription you'll need to include it with the claim.
- If your policy requires pre-authorization or a referral on file and the insurance company doesn't have one listed yet, you'll need to call the referral coordinator at your PCP's office. Ask them to file a referral for your physical therapy treatment that is dated to cover your first physical therapy visit. Be aware that referrals and pre-authorizations have an expiration date and some set a visit limit. If you are approaching the expiration date or visit limit you'll need the referral coordinator at your doctor's office to submit a request for more treatment.

This worksheet was created to assist you in obtaining reimbursement for physical therapy services and is not a guarantee of reimbursement to you.



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## Pediatric Patient History and Symptoms

Your answers to the following questions will help us to manage your child's care better. Please complete all pages prior to your child's appointment.

Date \_\_\_\_\_

Name of parent/guardian completing form \_\_\_\_\_

Child's name \_\_\_\_\_

Age \_\_\_\_\_

Child's grade \_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_

When did the problem first begin? \_\_\_\_\_

Since that time is it: ☐ staying the same ☐ getting worse ☐ getting better

Name and date of child's last doctor visit: \_\_\_\_\_

Date of last urinalysis: \_\_\_\_\_

Previous tests for the condition for which your child is coming to therapy. (Please list tests and results):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### MEDICATIONS

MEDICATIONS (PRESCRIPTION & OVER THE COUNTER)	START DATE	REASON FOR TAKING

Has your child stopped or been unable to do certain activities because of their condition? (For example, embarrassed to play with friends, can't go on sleepovers, feels ashamed about leakage and avoids play dates.)

☐ Yes ☐ No

Explain: \_\_\_\_\_

Does your child currently have or have a history of the following? Explain all "yes" responses below:

- ☐ Pelvic pain
- ☐ Low back pain
- ☐ Diabetes
- ☐ Latex sensitivity
- ☐ Allergies
- ☐ Asthma
- ☐ Other (please list) \_\_\_\_\_

- ☐ Blood in urine
- ☐ Kidney infections
- ☐ Bladder infections
- ☐ Vesicoureteral reflux Grade \_\_\_\_\_
- ☐ Physical or sexual abuse
- ☐ Surgeries

Explain yes responses and include dates \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child need to be catheterized? ☐ Yes ☐ No If yes, how often? \_\_\_\_\_

Ask your child to rate his/her feelings as to the severity of this problem from 0-10

0 \_\_\_\_\_ 10  
Not a problem Major problem

Rate the following statement as it applies to your child's life today: "My child's bladder is controlling his/her life."

0 \_\_\_\_\_ 10  
Not a problem Major problem



**BLADDER HABITS**

1. How often does your child urinate during the day? \_\_\_\_\_ # times per day, every \_\_\_\_\_ hours
2. How often does your child wake up to urinate after going to bed? \_\_\_\_\_ # times
3. Does your child awaken wet in the morning? ☐ Yes ☐ No If yes, \_\_\_\_\_ days per week
4. Does your child have the sensation (urge feeling) that they need to go to the toilet? ☐ Yes ☐ No
5. How long does your child delay going to the toilet once he/she needs to urinate?  
 \_\_\_\_\_ Not at all                      \_\_\_\_\_ 11-30 minutes  
 \_\_\_\_\_ 1-2 minutes                      \_\_\_\_\_ 31-60 minutes  
 \_\_\_\_\_ 3-10 minutes                      \_\_\_\_\_ Hours
6. Does your child take time to go to the toilet and empty their bladder? ☐ Yes ☐ No
7. Does your child have difficulty initiating the urine stream? ☐ Yes ☐ No
8. Does your child strain to pass urine? ☐ Yes ☐ No
9. Does your child have a slow, stop/start or hesitant urinary stream? ☐ Yes ☐ No
10. Is the volume of urine passed usually: ☐ Large ☐ Average ☐ Small ☐ Very small
11. Does your child have the feeling their bladder is still full after urinating? ☐ Yes ☐ No
12. Does your child have any dribbling after urination? (ex: once they stand up from the toilet.) ☐ Yes ☐ No
13. Fluid intake (one glass is 8 oz. or one cup)  
 \_\_\_\_\_ # of glasses per day (all types of fluid)  
 \_\_\_\_\_ # of caffeinated glasses per day  
 Typical types of drinks \_\_\_\_\_
14. Does your child have "triggers" that make him/her feel like he/she can't wait to go to the toilet?  
 (i.e. running water, etc.) ☐ Yes ☐ No  
 Please list: \_\_\_\_\_

**BOWEL HABITS**

14. Frequency of movements \_\_\_\_\_ per day \_\_\_\_\_ per week
15. Consistency: ☐ loose ☐ normal ☐ hard
16. Does your child currently strain to go? ☐ Yes ☐ No Ignore the urge to defecate? ☐ Yes ☐ No
17. Does your child have fecal staining on his/her underwear? ☐ Yes ☐ No How often? \_\_\_\_\_
18. Does your child have a history of constipation? ☐ Yes ☐ No  
 How long has it been a problem? \_\_\_\_\_

**SYMPTOMS QUESTIONNAIRE**

Bladder leakage (check all that apply):

- ☐ Never  
☐ When playing  
☐ While watching TV or video games  
☐ With strong cough/sneeze/exercise  
☐ With a strong urge to go  
☐ Nighttime sleep wetting

Frequency of urinary leakage-number (#) of episodes

- ☐ # per month  
☐ # per week  
☐ # per day  
☐ Constant leakage

Bowel leakage (check all that apply)

- ☐ Never  
☐ When playing  
☐ While watching TV or video games  
☐ With strong cough/sneeze/exercise  
☐ With a strong urge to go  
☐ Nighttime sleep leakage

Frequency of bowel leakage-number (#) of episodes

- ☐ # per month  
☐ # per week  
☐ # per day



**SYMPTOMS QUESTIONNAIRE CONTINUED**

Severity of urinary leakage (mark one)

- ☐ No leakage
- ☐ Few drops
- ☐ Wets underwear
- ☐ Wets outer clothing

Protection worn for urinary leakage  
(mark all that apply)

- ☐ None
- ☐ Tissue paper/paper towel
- ☐ Diaper
- ☐ Pull-ups

Severity of fecal leakage (mark one)

- ☐ No leakage
- ☐ Stool staining
- ☐ Small amounts in underwear
- ☐ Complete emptying

Protection worn for fecal leakage  
(mark all that apply)

- ☐ None
- ☐ Tissue paper/paper towel
- ☐ Diaper
- ☐ Pull-up

## Keeping a Record of Bladder Function

The main purpose of a bladder log is to document how your bladder functions. A log can give your health care provider an excellent picture of your bladder functions, habits and patterns. At first, the log is used as an evaluation tool. Later, it will be used to measure your progress on bladder retraining or leakage episodes. Please complete a bladder log every day for 3 days and bring it with you to your appointment.

Your log will be more accurate if you fill it out as you go through the day. It can be very difficult to remember at the end of the day exactly what happened in the morning.

### Instructions

#### COLUMN 1-TIME OF DAY

The log begins with midnight and covers a 24 hour period. Afternoon times are in bold. Select the hour block that corresponds with the time of day you are recording information.

#### COLUMN 2-TYPE & AMOUNT OF FLUID & FOOD INTAKE

- Record the type and amount of fluid you drank
- Record the type and amount of food you ate
- Record when you woke up for the day and the hour you went to sleep

#### COLUMN 3-AMOUNT VOIDED (URINATED): THREE METHODS

Record the time of day and amount voided. Use the first method unless directed by your health care provider to directly measure or count urine amounts. Record a bowel movement with a BM at the appropriate time.

1. Place an S, M, L, in the box at the corresponding time interval each time you urinate.  
 S - SMALL = seemed like a small amount, or urinated "just in case"  
 M - MEDIUM = seemed like an 8 ounce measuring cup would run over  
 L - LARGE = seemed like the amount you urinate when you first wake up in the morning
2. If you have difficulty gauging the amount of urine, you may record seconds by counting "one - one thousand" (this equals one second) while emptying your bladder. Record the total number of seconds it took to void.
3. Measure urine amounts with a collection device. The best method is a collection "hat" that can be placed directly over the toilet. Ask your provider where to get one. Some people use 2-4 cup measuring containers, but it is sometimes difficult to catch the urine with these. Record the measured ounces of urine in the box at the corresponding time interval each time you urinate.

#### COLUMN 4 - AMOUNT OF LEAKAGE

Record the amount of urine loss at the time it occurred.

S - SMALL = drop or two of urine      M - MEDIUM = wet underwear      L - LARGE = wet outerwear or floor

#### COLUMN 5 - WAS URGE PRESENT

Describe the urge sensation you had as:

- 1 - MILD = first sensation of need to go
- 2 - MODERATE = stronger sensation or need
- 3 - STRONG = need to get to toilet, move aside!

#### COLUMN 6 - ACTIVITY WITH LEAKAGE

Describe the activity associated with the leakage, i.e. coughed, heard running water, sneezed, bent over, lifted something or had a strong urge.

COMMENTS (at the bottom of the log table) Special problems and new or changes in medication are recorded here. If a pad change was needed, record the number used during the day at the bottom of the page.

## Daily Voiding Log Sample

TIME OF DAY	TYPE AND AMOUNT OF FOOD & FLUID INTAKE	AMOUNT VOIDED IN SECONDS OR S/M/L	AMOUNT OF LEAKAGE S/M/L	WAS URGE PRESENT 1/2/3	ACTIVITY WITH LEAKAGE
12:00 AM					
1:00					
2:00					
3:00					
4:00					
5:00					
6:00	Woke up at 6:45 am	L		3	
7:00	Coffee, bagel				
8:00			M		Fast walking
9:00	Apple	M		2	
10:00					
11:00		S		1	Key in the door
12:00 PM	Tuna sandwich, milk, pear				
1:00					
2:00		M		2	
3:00	Tea, cookies		S		Running water
4:00					
5:00					
6:00	Chicken, corn, pudding	M		3	
7:00					
8:00			S	3	
9:00					
10:00	To bed at 10:30	M		3	
11:00					

Comments: on vacation



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## Daily Bladder Log

Name: \_\_\_\_\_ Date: \_\_\_\_\_

TIME OF DAY	TYPE AND AMOUNT OF FOOD & FLUID INTAKE	AMOUNT VOIDED IN SECONDS OR S/M/L	AMOUNT OF LEAKAGE S/M/L	WAS URGE PRESENT 1/2/3	ACTIVITY WITH LEAKAGE
12:00 AM					
1:00					
2:00					
3:00					
4:00					
5:00					
6:00					
7:00					
8:00					
9:00					
10:00					
11:00					
12:00 PM					
1:00					
2:00					
3:00					
4:00					
5:00					
6:00					
7:00					
8:00					
9:00					
10:00					
11:00					

Comments: \_\_\_\_\_



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## Daily Bladder Log

Name: \_\_\_\_\_ Date: \_\_\_\_\_

TIME OF DAY	TYPE AND AMOUNT OF FOOD & FLUID INTAKE	AMOUNT VOIDED IN SECONDS OR S/M/L	AMOUNT OF LEAKAGE S/M/L	WAS URGE PRESENT 1/2/3	ACTIVITY WITH LEAKAGE
12:00 AM					
1:00					
2:00					
3:00					
4:00					
5:00					
6:00					
7:00					
8:00					
9:00					
10:00					
11:00					
12:00 PM					
1:00					
2:00					
3:00					
4:00					
5:00					
6:00					
7:00					
8:00					
9:00					
10:00					
11:00					

Comments: \_\_\_\_\_



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## Daily Bladder Log

Name: \_\_\_\_\_ Date: \_\_\_\_\_

TIME OF DAY	TYPE AND AMOUNT OF FOOD & FLUID INTAKE	AMOUNT VOIDED IN SECONDS OR S/M/L	AMOUNT OF LEAKAGE S/M/L	WAS URGE PRESENT 1/2/3	ACTIVITY WITH LEAKAGE
12:00 AM					
1:00					
2:00					
3:00					
4:00					
5:00					
6:00					
7:00					
8:00					
9:00					
10:00					
11:00					
12:00 PM					
1:00					
2:00					
3:00					
4:00					
5:00					
6:00					
7:00					
8:00					
9:00					
10:00					
11:00					

Comments: \_\_\_\_\_