PHYSICAL THERAPY SPECIALISTS

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: O M O F

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: O Google O Facebook O Yelp O 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:

Initial Evaluation..... $183 – $201
60 Minute Visits..... $156 – $180
Follow Up 30 Min Visits..... $78 – $91

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

- 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.
- If you arrive late to your scheduled appointment, you will be billed for the allotted time scheduled.
- Please report any health issues, even minor injuries to your PT before your session begins.
- Cell phones and pagers should be silenced.
- 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.
- Physical Therapy Specialists is not responsible for lost or stolen property.
- 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.

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 $50.00 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 $50.00 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 phone call, text or email. Let us know the method that works best for you.

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

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

Signature Print Name Date

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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):

o Primary Phone: _____
- o OK to leave voicemail message with detail information
- o OK to leave message with a family member
- o Leave message with call back number only

o Secondary Phone: _____
- o OK to leave voicemail message with detailed information
- o OK to leave message with a family member
- o Leave message with call back number only

Written Communication:
- o OK to email at this address: _____
- o OK to mail to my home address

My preferred method of contact for appointment reminders is: o Text o Voice Message o 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?_____

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

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.

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Patient History

NAME:	AGE:	DATE:

Previous PT? o Yes o No Previous PT for this issue? o Yes o No

1. Describe the current problem that brought you here: _____

2. When did your problem first begin? _____months ago or _____years ago
3. Was your first episode of the problem related to a specific incident? o Yes o No
   Please describe and specify date: _____
4. Since that time is it: o staying the same o getting worse o getting better
   Why or how? _____
5. Rate the severity of this problem from 0-10, with 10 being the worst: 1 2 3 4 5 6 7 8 9 10
6. If pain is present, rate pain on a 0-10, scale 10 being the worst: 1 2 3 4 5 6 7 8 9 10
   Describe the nature of the problem (i.e. constant burning, intermittent ache): _____
7. Date of last physical exam: _____ Tests performed _____
8. Describe previous treatment/exercises: _____
9. How has your lifestyle/quality of life been altered/changed because of this problem?
   Social activities (exclude physical activities): _____
   Diet /Fluid intake: _____
   Physical activity: _____
   Work, specify: _____
   Other: _____
10. Activities/events that cause or aggravate your symptoms - check all that apply:

o Sitting longer than _____minutes	o With cough/sneeze/straining
o Walking longer than_____minutes	o With laughing/yelling
o Standing longer than _____minutes	o With lifting/bending
o Changing positions (i.e. sit to stand)	o With cold weather
o Light activity (light housework)	o With triggers (running water/key in door)
o Vigorous activity/exercise (run/weight, lift/jump)	o With nervousness/anxiety
o Sexual activity	o No activity affects this problem
o Other, please list _____	

11. What relieves your symptoms? _____
12. What are your treatment goals? _____

NAME:

Since the onset of your current symptoms have you experienced:

- o Fever/chills
- o Unexplained weight change
- o Dizziness or fainting
- o Change in bowel or bladder functions
- o Other/describe _____
- o Malaise (unexplained tiredness)
- o Unexplained muscle weakness
- o Night pain/sweats
- o Numbness/tingling

General Health: o Excellent o Good o Average o Fair o Poor

Occupation _____

Hours/week _____ On disability or leave? o Yes o No Activity Restrictions? _____

Activity/Exercise: o None o 1-2 days/week o 3-4 days/week o 5+ days/week

Describe: _____

Mental Health: Currently seeing a therapist? o Yes o No

Current level of stress: o High o Med o Low

Have you ever had any of the following conditions or diagnoses?

- o Cancer
- o Heart problems
- o High Blood Pressure
- o Ankle swelling
- o Anemia
- o Low back pain
- o Sacroiliac/Tailbone pain
- o Alcoholism/Drug problem
- o Childhood bladder problems
- o Depression
- o Anorexia/bulimia
- o Smoking history
- o Vision/eye problems
- o Hearing loss/problems
- o Stroke
- o Epilepsy/seizures
- o Multiple sclerosis
- o Head Injury
- o Osteoporosis
- o Chronic Fatigue Syndrome
- o Fibromyalgia
- o Arthritic conditions
- o Stress fracture
- o Rheumatoid Arthritis
- o Joint Replacement
- o Bone Fracture
- o Sports Injuries
- o TMJ/ neck pain
- o Emphysema/chronic bronchitis
- o Asthma
- o Allergies-list below
- o Latex sensitivity
- o Hypothyroid/ Hyperthyroid
- o Headaches
- o Diabetes
- o Kidney disease
- o Irritable Bowel Syndrome
- o Hepatitis
- o HIV/AIDS
- o Sexually transmitted disease
- o Physical or Sexual abuse
- o Raynaud's (cold hands and feet)
- o Pelvic pain
- o Other/describe _____

Surgical/Procedure History:

- o Surgery for your back/spine
- o Surgery for your brain
- o Surgery for your female/male organs
- o Surgery for your bladder/prostate
- o Surgery for your bones/joints
- o Surgery for your abdominal organs
- o Other/describe _____

Obstetrics/Genecology *(females only):*

- o Childbirth vaginal deliveries # _____
- o Episiotomy # _____
- o C-section # _____
- o Difficult childbirth # _____
- o Prolapse or organ falling out
- o Other/describe _____
- o Vaginal dryness
- o Painful periods
- o Menopause (age):_____
- o Painful vaginal penetration
- o Pelvic pain

Males only:

- o Prostate disorders
- o Shy bladder
- o Pelvic pain
- o Other/describe _____
- o Erectile dysfunction
- o Painful ejaculation

NAME:

Medications

MEDICATIONS (PILLS, SHOT, PATCH)	START DATE	REASON FOR TAKING
OVER THE COUNTER (VITAMINS, ETC)	**START DATE**	**REASON FOR TAKING**

PELVIC SYMPTOM QUESTIONNAIRE

Bladder / Bowel Habits / Problems:

- o Trouble initiating urine stream
- o Urinary intermittent/slow stream
- o Trouble emptying bladder
- o Difficulty stopping the urine stream
- o Trouble emptying bladder completely
- o Straining or pushing to empty bladder
- o Dribbling after urination
- o Constant urine leakage
- o Blood in urine
- o Painful urination
- o Trouble feeling bladder urge/fullness
- o Current laxative use
- o Trouble feeling bowel/urge/fullness
- o Constipation/straining
- o Trouble holding back gas/feces
- o Recurrent bladder infections

o Other/describe _____

Frequency of urination

While awake: _____times per day

During sleep hours:_____times per night

When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?

_____ minutes _____hours _____not at all

The usual amount of urine passed is: o small o medium o large

Frequency of bowel movements:

_____ times per day _____times per week, or _____

When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet?

____minutes _____hours _____not at all

If constipation is present describe management techniques:_____

Average fluid intake (one glass is 8 oz. or one cup): _____ glasses per day

Of this total how many glasses are caffeinated?_____ glasses per day

Rate a feeling of organ "falling out"/prolapse or pelvic heaviness/pressure:

_____None present

_____Times per month (specify if related to activity or your period)

_____With standing for ____minutes or____hours

_____With exertion or straining

_____Other

NAME:

PELVIC SYMPTOM QUESTIONNAIRE CONTINUED

(skip the following if no leakage/incontinence occurs)

Bladder leakage – number of episodes
____No leakage
____Times per day
____Times per week
____Times per month
____Only with physical exertion/cough

Bowel leakage – number of episodes
____No leakage
____Times per day
____Times per week
____Times per month
____Only with physical exertion/cough

On average, how much urine do you leak?
____No leakage
____Just a few drops
____Wets underwear
____Wets the floor

How much stool do you lose?
____No leakage
____Stool staining
____Small amount in underwear
____Complete emptying

What form of protection do you wear? *(Please choose only one)*
____None
____Minimal protection (Tissue paper/paper towel/pantishields)
____Moderate protection (absorbent product, maxipad)
____Maximum protection (Specialty product/diaper)
____Other: _____

On average, how many pad/protection changes are required in 24 hours? _____ # of pads

PHYSICAL THERAPY EXPECTATIONS

We would like to determine your expectations for your physical therapy outcomes. In order to do so, please answer based on what you think will occur with your treatment versus what you would like to occur.

* At the end of physical therapy treatment, what do you expect will be the change associated with your condition?

o Worsen o Stay the same o Improve

* At the end of your physical therapy treatment, what do you expect will be your ability to perform a task you are currently unable to do (such as sit, walk, stand, clean house, play golf, etc.)?

o Worsen o Stay the same o Improve

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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: week before period

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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: _____