Name____**DOB** ___________________ **Date** ______________

Address____ **City**_____________________**State**___ **Zip**__________

Home Phone___________________ **Cell Phone** _______________________ **Work Phone** ____________________

E-mail Address ____

In Case of Emergency _____________________________ **Phone** ____

Informed Consent for Treatment

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and 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 evaluation, treatment and options available for my condition.

Payment

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies. Payment is due at the time of service. The fee for service for an initial evaluation is ________. The fee for service for all follow-up visits is ________.

Insurance

We are out of network with all insurance companies. As a courtesy we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. I understand that my insurance forms will be submitted by mail from FOUR CORNERS PHYSICAL THERAPY LLC. We have no contract or agreement with your insurance company. It is your responsibility to follow up on your reimbursements with your insurance company.
Not all insurance plans cover all services. In the event your insurance plan determines a service "not to be covered," you will be responsible for those charges. Please be aware that some insurance companies have a maximum number of visits that you are allowed; some companies also require prior-authorizations.

It is the patients' responsibility to know their physical therapy benefits, check with their insurer if any prior authorization is required and to follow up with our office if it was obtained & visits were approved.

Privacy Notice

FOUR CORNERS PHYSICAL THERAPY LLC maintains the privacy of patient health information. I am aware that a Notice of Privacy Policies is available in the waiting room and that I may ask our office staff or your Physical Therapist for a copy of the notice to take home with me.

I authorize the release of any medical information necessary to process the claim for services rendered to me.

I UNDERSTAND FOUR CORNERS PHYSICAL THERAPY, LLC FINANCIAL POLICY AND I AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND THAT SUCH TERMS MAY BE AMENDED BY THE PRACTICE FROM TIME TO TIME.

Patient /Guardian Signature____ Date:_______________________

Health History Name ____ DOB __________

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? Yes/No
Please describe and specify date.____

4. Since that time is it: staying the same / getting worse / getting better
Why or how? ____

5. If pain is present, rate pain on a 0-10 scale, 10 being the worst ________
Describe the nature of the pain (i.e. constant burning, intermittent ache) ____________________________________

6. Describe previous treatment/exercises ____

7. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

___ Sitting greater than minutes
___ Walking greater than minutes
___ Standing greater than minutes
___ Changing positions (ie. - sit to stand)
___ Light activity (light housework)
___ Vigorous activity/exercise (run/weight lift/jump)
___ Sexual activity
___ Other, please list
___ With cough/sneeze/straining
___ With laughing/yelling
___ With lifting/bending
___ With cold weather
___ With triggers -running water/key in door
___ With nervousness/anxiety
___ No activity affects the problem

8. What relieves your symptoms? ____

9. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify______________________________________
Diet /Fluid intake, specify ____
Physical activity, specify____
Work, specify ____
Other ____

10. Rate the severity of this problem from 0 -10, with 0 being no problem and 10 being the worst _____

11. What are your treatment goals/concerns?____
____

Since the onset of your current symptoms, have you had?

Y/N Fever/Chill
Y/N Unexplained weight change
Y/N Dizziness or fainting
Y/N Change in bowel or bladder functions
Y/N Malaise (Unexplained tiredness)
Y/N Unexplained muscle weakness
Y/N Night pain/sweats
Y/N Numbness / Tingling
Other/Describe___________

<u>Health History</u>: Date of Last Physical Exam________ Tests performed ____

General Health:
Excellent Good Average Fair Poor Occupation __________________________________
Hours/week ______ On disability or leave? ________Activity Restrictions? ______________________________________

Pg 2 History **Name**____

Mental Health: Current level of stress High___ Med____ Low____ Current psych therapy? Y/N
Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week
Describe ____

Have you ever had any of the following conditions or diagnoses? CIRCLE all that apply /describe

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

Surgical /Procedure History

Y/N Surgery for your back/spine
Y/N Surgery for your brain
Y/N Surgery for your female organs
Y/N Surgery for your bladder/prostate
Y/N Surgery for your bones/joints
Y/N Surgery for your abdominal organs
Other/describe____

Ob/Gyn History (females only)

Y/N Childbirth vaginal deliveries #___
Y/N Episiotomy # ___
Y/N C-Section # ____
Y/N Difficult childbirth # _____
Y/N Prolapse or organ falling out _______
Y/N Vaginal dryness
Y/N Painful periods
Y/N Menopause - when?____
Y/N Painful vaginal penetration
Y/N Pelvic pain
Y/N Other /describe ____

Males only

Y/N Prostate disorders
Y/N Shy bladder
Y/N Pelvic pain
Y/N Erectile dysfunction
Y/N Painful ejaculation
Y/N Other /describe____

Medications - pills, injection, patch Start date Reason for taking

____
____
____

Over the counter -vitamins etc Start date Reason for taking

____
____
____

FOUR corners
PHYSICAL THERAPY

Pg 3 History **Name**____

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Problems:

Y/N Trouble initiating urine stream
Y/N Urinary intermittent /slow stream
Y/N Painful urination
Y/N Trouble emptying bladder
Y/N Trouble feeling bladder urge/fullness
Y/N Difficulty stopping the urine stream
Y/N Current laxative use
Y/N Straining or pushing to empty bladder
Y/N Trouble feeling bowel/urge/fullness
Y/N Dribbling after urination
Y/N Constipation/straining
Y/N Constant urine leakage
Y/N Trouble holding back gas/feces
Y/N Recurrent bladder infections
Y/N Other: Describe____

1. Frequency of urination: Awake Hours: times/day_____ Sleep Hours: times/night ____

2. 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 ____

3. The usual amount of urine passed is:___small ____ medium ____large

4. Frequency of bowel movements: times/day ____ or times/week ____

5. When you have a bowel movement urge, how long can you delay before you have to go to the toilet? ____ minutes, ___ hours, ___ not at all

6. If constipation is present, describe management techniques: ______________________________

7. 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.

8. 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

Skip remaining questions if no leakage/incontinence

9a. Bladder leakage – number of episodes**.**

___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

9b. Bowel leakage - number of episodes

___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

10a. On average, how much urine do you leak?

__ No leakage
__ Just a few drops
__ Wets underwear
__ Wets outerwear
__ Wets the floor

10b.How much stool do you lose?

__ No leakage
__ Stool staining
__ Small amount in underwear
__ Complete emptying

11. What form of protection do you wear? (Please complete only one)

___ None
___ Minimal protection (Tissue paper/paper towel/panty shields)
___ Moderate protection (absorbent product, maxi pad)
___ Maximum protection (Specialty product/diaper)

12. On average, how many pad changes required in 24 hour period? __ # of pads

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Patient /Guardian Signature ____________________________________ Date: ____________________

CANCELLATION POLICY Name ____________________________________

Cancellation/No Show/Late Policy:

We understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, flight delays, car problems, snowstorms, and illness are just a few reasons why one might consider canceling an appointment. In our desire to be effective and fair to all of our clients and out of consideration for our therapists' time, we have adopted the following policies:

Cancellations

Our practice requires 24 hours notice BUSINESS DAY prior to your appointment; otherwise, you will be charged $50.00. If your appointment is on a Monday, please leave a voice message over the weekend, in order to avoid a cancellation penalty.

No-shows

Anyone who either forgets or consciously chooses to forgo his or her appointment for whatever reason, will be considered a "no-show". **They will be charged for the "full" session** and future service will be denied until payment is made.

Arriving Late

Appointment times have been arranged specifically for you. If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Regardless of the length of the treatment actually given, **you will be responsible for the "full" session**.

I have read and understand FOUR CORNERS PHYSICAL THERAPY, LLC cancellation policies and I agree to be bound by its terms.

Patient /Guardian Signature ____________________________________ Date: ____________

<u>Privacy/Information Exchange</u>

<u>Email Authorization</u>

FOUR CORNERS PHYSICAL THERAPY, LLC is equipped to relay information to you using email. Due to the "HIPPA Notice of Privacy Practices" we need your permission to communicate with you electronically. Please note, although every effort is made to ensure patient privacy, Four Corners cannot assure confidentiality of information sent electronically. Four Corners cannot be held liable for security risks.

By signing below, you grant permission for practitioners and staff of Four Corners to contact you via email to discuss your care.

Patient Name: ___________________________

Patient DOB: ____/____/_____

Patient Signature: _____________________________

Patient Personal Email: _________________________

Four Corners will also use this means to send you periodic updates about activities at our office. These might include changes in policies, closing of the office due to inclement weather or emergency, new service offerings, newsworthy health research findings, our Four Corners newsletter, special offers and invitations to events.

PLEASE NOTE: We will never share your email address with anyone.