LAKE CENTRE for REHAB

PELVIC FLOOR
Physical Therapy
...more than just Kegels!

Dear New Patient:

To help treat your condition, your doctor has recommended a type of physical therapy called ***Pelvic Floor Physical Therapy***. If you are unfamiliar with this type of therapy, you are not alone. However, research points to its high success rate, all without drugs or surgery. In fact, over 90% of our patients report an 80-100% improvement in their symptoms by the end of therapy, and only 1-2% report no change at all. So, the odds are very good that we will be able to help you.

Many bowel, bladder, and pain conditions in the pelvis are due to poorly functioning muscles. Your "pelvic floor" is a muscle group at the bottom of your pelvis that has two main functions: 1) postural support to the pelvic organs (bladder, bowel, uterus, and prostate) and 2) voluntary control over bowel and bladder function.

Pelvic Floor Muscle Dysfunction Categories

1. **Weak and sagging**
   - Loss of control over your bladder or bowels (incontinence)
   - Pelvic organ prolapse (fallen bladder, bowels, and/or uterus)
2. **Tight and spasming**
   - Trouble with elimination (urinary retention, constipation)
   - Pelvic pain (with sitting, during intercourse)

Pelvic Floor Rehab is ***not*** the same as Kegel exercises. Like traditional physical therapy, we will use techniques that will strengthen weak muscles and stretch and massage tight muscles. Our team has expert training in how to modify traditional therapy techniques in order to treat the pelvic floor area in ways that will make you feel comfortable.

Please take the time to fill out the enclosed questionnaire. It will help us better plan your treatment. There may be questions that at first, you wouldn't think would apply to you, but since pelvic floor problems can affect bowel, bladder and sexual function, it is not uncommon to have symptoms in more than one category.

Your evaluation and first treatment with your therapist will take about an hour, will be one-on one, and in a private, quiet area. Please dress in comfortable, loose-fitting clothing. You are welcome to bring a friend or family member with you. Most patients will require 12-16 treatment sessions that will last about 45-60 minutes each. Please call with any questions or concerns you might have. We look forward to meeting you.

Sincerely,

Your Pelvic Floor Rehab Team

Tracey Goldstein-Marquez, PT, MPT
Donna Goldstein, PT
Filamae Garanica-Tapiculin, PT
Lori Yoder, PTA

LAKE CENTRE for REHAB

NEW PATIENT INFORMATION SHEET

HOW DID YOU HEAR ABOUT US? ☐ PHYSICIAN ☐ WEBSITE ☐ FACEBOOK
☐ SEMINAR ☐ NEWSPAPER AD ☐ FRIEND ☐ RETURNING PATIENT ☐ OTHER_____

Name (First)_____(Middle)_____(Last)_____(Suffix)_____

Mailing Address_____

(City)_____(State)_____(ZIP)_____

Phone: Home_____Cell_____Work_____

Primary Phone _____Email Address_____

Date of Birth_____Age_____Marital Status: ☐Married ☐Divorced ☐Single ☐Other ☐ Unknown

☐Widowed ☐Separated Gender: ☐Male ☐Female Social Security #_____

Driver License #_____

Employment Status: ☐Full Time ☐Part Time ☐Not Employed ☐Self-Employed ☐Retired ☐Active Military ☐Unknown ☐Full Time Student

In case of emergency, please notify_____Phone_____

Attorney involvement? ☐Yes ☐No Attorney name_____Phone_____

Name of Employer, Parent or Guarantor_____

Street Address of Employer or Parent_____

City, State and ZIP of Employer or Parent_____

Name of Spouse_____Spouse Date of Birth_____

Spouse's Employer_____Phone_____

Have you received any therapy this year? ☐Yes ☐No

Have you been seen for nursing or physical therapy services in your home by a Home Health Agency prior to requesting services through our organization? ☐Yes ☐No If yes, name of home health agency_____

_____

Primary Care Provider/Family Doctor_____Phone_____

****

The two documents listed below are available for review at the Lake Centre for Rehab front office. Your signature below indicates agreement with the two forms listed below.

1. Authorization for Treatment, Assignment of Benefits, Payment Responsibility and Disclosure of ALF Resident Information.
2. Acknowledgement of Receipt of Privacy Notice in combination with Voluntary Consent.

The listed individuals may have access to my PHI (Protected Health Information): _____

_____

_____ _____

Patient/Representative Signature Date Witness Date

_____ _____

Guardian Signature if patient is a minor Date Relationship to Patient

LAKE CENTRE for REHAB

Patient Name_____**Date**_____

Female Pelvic Floor Questionnaire

HOW DID YOU HEAR ABOUT US? ☐ PHYSICIAN ☐ WEBSITE ☐ FACEBOOK
☐ SEMINAR ☐ NEWSPAPER AD ☐ FRIEND ☐ RETURNING PATIENT ☐ OTHER_____

Have you recently traveled out of this country? Yes ☐ No ☐
Have you had direct/indirect prolonged contact with someone with a confirmed case of coronavirus? Yes ☐ No ☐

Conditions related to the pelvic floor muscles can affect bladder, bowel, sexual, and physical function. Please answer the questions below so that we can better understand your problem. Please check all that apply.

History of Current Condition

Reason for today's visit_____
How long have you had this problem?_____
Since the problem began, has the problem become: ❑ Worse ❑ Better ❑ Unchanged
Is it related to an injury or accident? ❑ No ❑ Yes Explain how and when_____
What are your goals for treatment?_____

Previous **Treatments** for your condition:

❑ Kegel exercises	❑ Rectocele repair	❑ Tubal ligation	❑ Massage therapy
❑ Biofeedback	❑ Hemorrhoid repair	❑ Infertility treatments	❑ Chiropractor
❑ Pelvic floor rehab	❑ Radiation	❑ Removal of endometria	❑ Acupuncture
❑ Diet/fluid changes	❑ Ostomy pouch	❑ Removal of adhesions	❑ Vaginal dilators
❑ Pessary	❑ Hemorrhoid cream	❑ Hysterectomy	❑ Over the counter pain meds
❑ Bladder surgery	❑ High fiber diet	❑ Abdominal	❑ Prescription pain meds
❑ Bladder control meds	❑ Probiotics	❑ Vaginal	❑ Bladder instillations
❑ Collagen injections	❑ Stool softeners	❑ With bladder repair	❑ Urethral/bladder dilation
❑ InterStim	❑ Constipation meds	❑ One ovary removed	❑ Nerve injections/blocks
❑ Self-catheterization	❑ Anti-diarrheal meds	❑ Both ovaries removed	❑ Other_____
❑ BCG	❑ Herbal supplements	Reason_____	
	❑ Enemas	Age_____	

Have you received therapy for the current or other problem in the past year? ❑ Yes ❑ No If yes, indicate type (physical therapy, speech therapy, etc.) and date_____

Previous **Tests** for your condition:

❑ Urodynamics study	❑ Video defacography	❑ X-ray	❑ Hysteroscopy
❑ Bladder scan (PVR)	❑ Colonoscopy	❑ CT scan	❑ Potassium test
❑ Cystoscopy	❑ Anal manometry	❑ MRI	❑ Exploratory surgery

Medical Conditions and Health Status

Please rate your overall health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor
With whom do you live? ❑ Alone ❑ Spouse/significant other ❑ Other relative(s) ❑ Roommate(s)
Where do you live? ❑ Private home or apartment ❑ Independent living ❑ Assisted living ❑Other_____

Bladder	❑ Urinary incontinence	❑ Small bladder capacity	❑ Bladder cancer	❑ Bladder infections (UTI's)
	❑ Overactive bladder	❑ Large bladder capacity	❑ Interstitial cystitis	❑ Painful bladder syndrome
	❑ Urinary retention	❑ Fallen bladder (cystocele)	❑ Other_____	
Bowels	❑ Fecal incontinence	❑ Ulcerative colitis	❑ Hemorrhoids	❑ Colon cancer
	❑ Constipation	❑ Spastic colon	❑ Lactose intolerance	❑ Anal cancer
	❑ Diarrhea	❑ Diverticulitis	❑ Gluten intolerance	❑ Colostomy/ileostomy
	❑ Irritable bowel synd.	❑ Diverticulosis	❑ Other_____	

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Patient Name_____**Date**_____

Obstetrical

_____ Number of pregnancies
_____ Number of vaginal deliveries
_____ Number of C-Section deliveries
_____ Weight of largest baby
I'm pregnant now; due date_____

❑ Vaginal tear
❑ Episiotomy
❑ Vaginal stitches
❑ Use of forceps or suction
❑ Other complications_____

Gynecological

❑ Endometriosis
❑ Vulvodynia
❑ Vaginismus
❑ Pudendal neuralgia
❑ Cervical cancer
❑ Ovarian cancer
❑ Uterine cancer
❑ Yeast infections
❑ Ovarian cysts
❑ Uterine fibroids
❑ Uterine prolapse
❑ Bladder (cystocele)
❑ Rectum (rectocele)
❑ "Falling out" feeling
❑ Bulge in the vagina
❑ Other_____

Menstruation Status
❑ Normal periods
❑ Irregular periods
❑ Painful periods
❑ Peri-menopausal
❑ Post-menopausal
❑ Hysterectomy

Use of Hormones
❑ None used
❑ Birth control pills
❑ Estrogen replacement
❑ Oral medication
❑ Skin patch
❑ Vaginal cream
❑ Suppository

Sexual Function: ❑ I'm sexually active
❑ I'm not sexually active due to: ❑ My pelvic pain symptoms ❑ For non-health related reasons ❑ *My other* medical problems ❑ *My partner's* medical problems

Other Medical

❑ High blood pressure
❑ Low blood pressure
❑ High cholesterol
❑ Heart disease
❑ Heart attack
❑ Angina
❑ Congestive heart failure
❑ Cardiac arrhythmia
❑ Pacemaker/defibrillator
❑ Vascular disease
❑ Swollen legs/edema
❑ Emphysema
❑ Bronchitis
❑ Asthma
❑ Cigarette smoker
❑ Former smoker
❑ Migraine headaches
❑ Stroke
❑ TIA (mini strokes)
❑ Parkinson's Disease
❑ Multiple Sclerosis
❑ Seizures
❑ Hypothyroidism
❑ Kidney disease
❑ Kidney stones
❑ Sleep apnea
❑ Diabetes
❑ Acid reflux
❑ Depression
❑ Anxiety disorder
❑ Glaucoma
❑ Cataracts
❑ Glasses
❑ Hearing loss
❑ Fibromyalgia
❑ Osteoporosis
❑ Osteopenia
❑ Low back pain
❑ Tailbone trauma
❑ Sciatica
❑ Stenosis
❑ Arthritis Area_____
❑ Herniated disc Level_____
❑ Degenerative disc Area_____
❑ Bone fracture Area_____
❑ Cancer Area_____
❑ Other_____

Surgeries	Age or Year	Medications	For what condition?

Allergies

❑ None ❑ Latex sensitivity ❑ Seasonal (pollen/hay fever) ❑ Bees ❑ Other_____
❑ Food_____ ❑ Medications_____

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Patient Name_____**Date**_____

Review of Systems - Please check if you have you recently had any of these symptoms.			
❑ Fever/chills	❑ Eye pain/redness	❑ Stomach pain	❑ Tremors
❑ Weight change	❑ Chest pain	❑ Bloody stools	❑ Speech changes
❑ Fatigue/night sweats	❑ Pounding heart	❑ Tarry stools	❑ Seizures
❑ Skin rash/itch	❑ Shortness of breath	❑ Blood in urine	❑ Loss of consciousness
❑ Headaches	❑ Calf pain	❑ Muscle pain	❑ Vertigo/spinning
❑ Hearing loss	❑ Leg swelling	❑ Neck/back pain	❑ Unsteadiness
❑ Ringing in ears	❑ Cough	❑ Joint pain	❑ Lightheaded
❑ Ear pain/discharge	❑ Coughing up blood	❑ Falls	❑ Depression
❑ Nose bleeds	❑ Phlegm production	❑ Arm/leg weakness	❑ Nervous/anxious
❑ Sore throat	❑ Congestion	❑ Lack of coordination	❑ Suicidal thoughts
❑ Blurred vision	❑ Wheezing	❑ Difficulty walking	❑ Hallucinations
❑ Double vision	❑ Heartburn	❑ Difficulty standing up	❑ Substance abuse
❑ Light sensitive	❑ Nausea/vomiting	❑ Tingling/numbness	❑ Memory loss
Is your doctor aware of these recent symptoms? ❑ Yes ❑ No			

Please answer the questions below. If your symptom severity fluctuates, characterize your symptoms at their worst.

Bladder Health Do you have a urologist? ❑ Yes ❑ No If yes, who?_____

1. During the **daytime**, how often do urinate? ❑ Every 30-60 minutes ❑ 1-2 hours ❑ 2-3 hours ❑ 3-4 hours ❑ More than 4 hours
2. During the **nighttime** (after you've fallen asleep), how often do you get up to urinate? ❑ 0-1 times per night ❑ 2-3 times ❑ 3-4 times ❑ More than 4 times
3. How many **8 ounce servings** (cups) do you drink of the following?

Liquid	Per Day	Per Week	On Occasion	Never	Liquid	Per Day	Per Week	On Occasion	Never
Coffee (❑ Reg. ❑ Decaf)					Water				
Tea (❑ Reg. ❑ Decaf)					Milk				
Soda (❑ Reg. ❑ Decaf)					Juice				
Beer/Wine/Liquor					Other_____				

4. Do you **every lose urine (even a few drops**) with any of the situations below?

	Never	**On Occasion**	**Sometimes**	**Usually**	**Always**
Cough					
Sneeze					
Laugh					
Getting out of a chair					
Getting out of a car					
Getting out of bed at night					
Getting out of bed in the morning					
Picking objects off the floor					
Putting on shoes or clothes					
Lifting light items					
Lifting heavy items					
Cooking or doing dishes					
Doing housework					
Doing yard work					
During sexual activity					
Walking to the toilet at home					
Shopping or running errands					
Standing or walking for a long time					
Walking to toilet in public					

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Patient Name_____**Date**_____

	Never	On Occasion	Sometimes	Usually	Always
Recreational activities					
Exercise activities					
Other_____					

5. Do you ever have **strong or difficult-to-control urges** to urinate with the situations listed below?

	Never	On occasion	Sometimes	Usually	Always
Around running water					
Feeling cold					
Feeling anxious or nervous					
Unlocking the door					
If I've waited too long					
Rushing off to the toilet					

6. How long can you **usually delay an urge** to urinate? ❑ I rarely feel urges to void ❑ I go as soon as I feel an urge ❑ 1-2 minutes ❑ Several minutes ❑ 10-15 minutes ❑ 15 minutes or more

7. What **type of protective padding** do you use for bladder control? ❑ None needed ❑ Change underwear ❑ Folded tissue paper ❑ Liners ❑ Thin pads ❑ Thick pads ❑ Diapers ❑ Other_____

8. How often do you **change your bladder protection**? ❑ None ❑ Only when I leave the house ❑ Only at night ❑ Only during a cold ❑ Only during exercise ❑ 1-2 per day ❑ 3-4 per day ❑ 4+ per day

9. How **saturated** does your protection get? ❑ No leakage ❑ "Near misses" ❑ A few drops ❑ Damp ❑ Wet ❑ Soaked ❑ Overflows onto clothes

10. How often do you go to the bathroom **before you feel urges** to void, "just in case?" ❑ Never ❑ On occasion ❑ Sometimes ❑ Usually ❑ Always

11. How often do you **avoid drinking** fluid in order to help with bladder control? ❑ Never ❑ On occasion ❑ Sometimes ❑ Usually ❑ Always

12. Do you ever notice any of the following **bladder symptoms**? Please check how often.

	Never	On occasion	Sometimes	Usually	Always
Weak stream					
Incomplete bladder emptying					
Trouble starting urine stream					
Strain to urinate					
Dribble after urinating					
Have to rock pelvis to empty bladder					
Have to push over the bladder to empty					
Splint or support bladder to urinate					
Pain as my bladder *fills*					
Location:	❑ Bladder ❑ Urethra ❑ Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				
Pain as my bladder *empties*					
Location:	❑ Bladder ❑ Urethra ❑ Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				

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Patient Name_____**Date**_____

Bowel Health

Do you have a gastroenterologist? ❑ Yes ❑ No If yes, who?_____

1. **How often** do you have a bowel movement? ❑ Less than 3 times a week ❑ Every 2-3 days ❑ Every 1-2 days ❑ Daily ❑ 2-3 times per day ❑ More than 3 times per day ❑ I won't go for several days, and then go multiple times in one day
2. What is the **consistency** of your bowel movements? ❑ Watery/formless ❑ Loose and thin ❑ Soft and formed ❑ Hard and rocky ❑ Small and pellet-like ❑ It varies_____
3. Do you ever **lose feces** with any of the situations below? Please check how often.

	Never	On Occasion	Sometimes	Usually	Always
On the way to the toilet					
If I exert myself					
When I pass gas					
I have fecal soiling without an urge to have a BM					

4. What **type of protective padding** do you use for bowel control? ❑ None needed ❑ Change underwear ❑ Folded tissue paper ❑ Liners ❑ Thin pads ❑ Thick pads ❑ Diapers ❑ Other_____
5. How often do you **change your bowel protection**? ❑ None ❑ Only when I leave the house ❑ Only when I have diarrhea/ loose stools ❑ 1-2 per day ❑ 3-4 per day ❑ 4+ per day
6. Do you every notice any of the following **bowel symptoms**? Please check how often.

	Never	On occasion	Sometimes	Usually	Always
Excessive straining during a BM					
Support/splint rectum during BM					
Incomplete BM's					
Rush to the toilet with BM urge					
Trouble controlling gas in public					
Excessive wiping needed after BM					
Fecal soiling in underwear after BM					
Pain as my bowels *fill*					
Location:	❑ Rectum ❑ Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				
Pain as my bowels *empty*					
Location:	❑ Rectum ❑ Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				

GYN Health

Do you have an OB/GYN? ❑ Yes ❑ No If yes, who?_____

Vulvar symptoms: ❑ Dryness ❑ Itching ❑ Discharge ❑ Numbness/tingling ❑ Redness ❑ Swelling

Pelvic pain symptoms: ❑ None
❑ My pelvic symptoms **affect my ability** to, OR **I feel worse when I try** to: Check all that apply.

❑ Sleep	❑Do yard work	❑ Get out of a car	❑Perform work duties
❑ Bathe	❑Bend forward	❑ Climb stairs	❑Recreational activities
❑ Get dressed	❑Squat down	❑ Sitting tolerance	❑Social events
❑ Wear tight clothing	❑Lift items	❑ Standing tolerance	❑Travel
❑ Wear a tampon	❑Reach overhead	❑ Walking distance	❑Exercise for health
❑ Cook meals	❑Get out of bed	❑ Drive a car	❑Have a GYN exam
❑ Do housework	❑Stand up from a chair	❑ Run errands/shop	❑Do Kegel exercises

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Patient Name_____**Date**_____

Pain Location: Check all that apply.

❑ Abdomen	❑ Inner thighs	❑ Side/waist	❑ Over tight surgical scars	❑ Vagina
❑ Clitoris	❑ Urethra	❑ Bladder	❑ Tailbone	❑ Rectum
❑ Low back	❑ Buttocks	❑ Groin	❑ Sides of hips	❑ Back of hips
❑ Front of hips				

Circle pain severity: No Pain 0___1___2___3___4___5___6___7___9___10 Worst Pain

Pain with sexual activity:

❑ None

❑ I limit the *frequency* of sexual activity because of my pain.

❑ I have to *interrupt* intercourse due to pain.

❑ I *avoid it* altogether due to my pain. Last intercourse attempt: _____

The pain occurs during: ❑ Vulvar touching ❑ Vaginal penetration ❑ Thrusting ❑ Orgasm

For how long? ❑ Only during sexual activity ❑ For a few hours afterwards ❑ For a day or more afterwards

Location: ❑ Vaginal opening ❑ Clitoris ❑ Deep in my pelvis ❑ In my back

Circle pain severity: No pain 0___1___2___3___4___5___6___7___9___10 Worst Pain

Patient signature_____

LAKE CENTRE for REHAB

AUTHORIZATION
FOR
TREATMENT, ASSIGNMENT OF BENEFITS, PAYMENT RESPONSIBILITY
AND DISCLOSURE OF ALF RESIDENT INFORMATION

1. I hereby consent to treatment by Lake Centre for Rehabilitation ("LCR") as outlined in the treatment Plan of Care developed in collaboration with my attending physician.
2. MEDICARE: Patients who are covered by Medicare are responsible for their annual deductible and the 20% portion of the Medicare allowed benefit amount for covered services. I understand Medicare does not pay for all of my therapy costs. Medicare only pays for 80% of the covered benefit. My covered outpatient therapy benefit is as stated in the federal guidelines, unless I qualify for an exception to the benefit limit. If I receive therapy service that is not a Medicare covered benefit, I am responsible for payment, personally or through any other insurance I may have. The purpose of this notification is to help me make an informed choice about whether or not I want to receive therapy services, knowing I may have to pay for the services myself. I understand that LCR will bill my secondary insurance carrier. I authorize LCR to furnish my insurance company any information needed to process the claim. I assign to LCR all money paid for the rehabilitation services furnished. I agree to pay all deductibles, co-insurance and non-covered items not paid for by my secondary insurance carrier. I will notify LCR if I am eligible for coverage with Tricare for Life Health Care System. I certify that the information given me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the holder of any medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf to LCR.
3. PRIVATE: I understand that every effort will be made by LCR to bill my insurance carrier for services rendered. I authorize LCR to furnish my insurance company any information needed to process the claim. I assign to LCR all money paid for the rehabilitation services furnished. LCR DOES NOT accept assignment on non-contracted claims. Any amount not paid by my insurance company is my direct responsibility. I also understand that it is my responsibility to see that all claims are paid within 30 days of receipt. If claims are not paid by 60 days, I will be responsible for payment of the claim (IN FULL) at that time. Any balance due after 60 days may be subject to a delinquency fee of 1% per month. I understand that health and accident insurance policies are an arrangement between my insurance company and myself, that all services rendered me are charged directly to me, and that I am personally responsible for payment.
4. WORKERS' COMPENSATION: Patients who are covered under Workers' Compensation are not financially responsible for services rendered unless their claim is controverted/denied. If this occurs, I understand that I am immediately responsible for all controverted/denied charges regardless of pending litigation.
5. MANAGED CARE PLANS: Patients who are covered under a participating Managed Care Plan are responsible for any applicable deductibles and/or co-payments required under their plan. I understand that I am responsible for payment of any applicable deductibles and/or co-payments under my plan at the time services are rendered.
6. I, and Patient if applicable, agree to execute any documents and perform any acts that Provider may reasonably request. <u>The undersigned warrants and represents that attached hereto are originals or certified copies of any applicable Powers of Attorney, Health Care Surrogate forms or Court Orders appointing the undersigned as the legal guardian of the Patient</u>.
7. I UNDERSTAND THAT IF I FAIL TO MAKE MY APPOINTMENT AT THE TIME RESERVED FOR ME, WITHOUT A 24-HOUR PRIOR NOTICE, I WILL BE SUBJECT TO A $25.00 FEE. If I do not show up for three (3) appointments, I may forfeit all subsequent appointments and be discharged or placed on a call list for open appointment times if available.
8. I agree that the provisions hereof shall continue in full force and effect until Provider has received written notice of termination signed by the undersigned; provided, however, that the provisions of Paragraphs 2, 3, 4, 5, 6, 7 and 8 shall survive any such termination.
9. **Your signature at the bottom of the New Patient Information Sheet indicates your agreement with the above terms.**

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Patient Name_____Date_____

PELVIC FLOOR INFORMED CONSENT FOR EVALUATION AND TREATMENT OF PELVIC FLOOR DYSFUNCTIONS

The term, "informed consent," means that the potential risks, benefits and alternative of therapy evaluation and treatment have been explained to me. 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.

I understand that if I am referred to physical therapy for pelvic floor dysfunction, it may be beneficial for my therapist to perform a muscle assessment of the pelvic floor, initially and periodically to assess muscle strength, length and range of motion and scar mobility. Palpation of these muscles is most direct and accessible if done via the vagina and/or rectum. Pelvic floor dysfunctions include pelvic pain syndromes, urinary incontinence, fecal incontinence, dyspareunia or pain with intercourse, pain from episiotomy or scarring, vulvodynia, vestibulitis, persistent sacroiliac joint dysfunction/ low back pain, or other similar complications. Evaluation of my condition may include observation, soft tissue mobilization, use of vaginal cones, and vaginal or rectal sensors for muscle education and/or electrical stimulation.

I understand that the benefits of the vaginal/rectal assessment have been explained to me. I understand that if I am uncomfortable with the assessment or treatment procedures AT ANY TIME, I will inform my therapist, and the procedure will be discontinued and an alternative discussed with me.

Treatment procedures for pelvic floor dysfunctions may include, without limitation, education, exercise, stimulation, ultrasound, and several manual therapy techniques including massage, joint and soft tissue mobilization. The therapist will explain all of the treatment procedures to me, and I may choose to not participate with all or part of the treatment plan. I understand that no guarantees have been or can be provided to me regarding the success of therapy.

I have received instructions on a three-dimensional, anatomical model to better understand muscle and organ location, hand placement, and palpation techniques that are common in the treatment of pelvic floor muscle conditions or disorders.

Potential Risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary. If pain or discomfort does not subside in 1 to 3 days, I agree to contact my therapist.

I have read, or had read to me, the foregoing, and any questions which may have occurred to me have been answered to my satisfaction. I understand the risks, benefits and alternatives of the treatment.

Based on the information I have received from the therapist, I voluntarily agree to standard assessment and muscular treatment techniques of the perineal area.

___ I am comfortable with only the therapist performing the evaluation in the room.

___ I would prefer to have a chaperone in the room while the therapist performs the evaluation.

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Patient Name_____Date_____

*** *If you are pregnant, have an infection of any kind, have vaginal dryness, are less than 6 weeks post partum or post surgery, have severe pelvic pain, sensitivity to creams, please inform the therapist prior to pelvic floor assessment.*

Evaluation:

Patient Signature	Date	Therapist Signature	Date

Treatments:

Patient Signature	Date	Therapist Signature	Date
Patient Signature	Date	Therapist Signature	Date
Patient Signature	Date	Therapist Signature	Date
Patient Signature	Date	Therapist Signature	Date
Patient Signature	Date	Therapist Signature	Date
Patient Signature	Date	Therapist Signature	Date
Patient Signature	Date	Therapist Signature	Date
Patient Signature	Date	Therapist Signature	Date
Patient Signature	Date	Therapist Signature	Date
Patient Signature	Date	Therapist Signature	Date
Patient Signature	Date	Therapist Signature	Date

Taken from APTA Sect on Women's Health, Sher Pelvic Health and Healing and 3rd Source not named from the internet.

REHAB THERAPY WORKS

SCREENING FORM

Patient Name _____ Facility _____

Effective January 1, 2022, the Medicare "Cap" starts at $2,150 for physical and speech therapy services combined, and $2,150 for occupational therapy services, billed by an outpatient provider for the purposes of applying the KX modifier. Each provider is required to track the entire therapy episode, regardless of setting. When the Cap exceeds $3,000, there may be additional scrutiny of the claim by Medicare for medical necessity. Services can only be denied for medical necessity reasons.

Previous Therapy

1. Since the first of the year, have you received Part B therapy services in a skilled nursing facility?
   □ Yes □ No If yes, by whom and how much? _____
   _____
2. Since the first of the year, have you received Part B therapy services in a physician's office?
   □ Yes □ No If yes, by whom and how much? _____
   _____
3. Since the first of the year, have you received Part B therapy services in an outpatient clinic?
   □ Yes □ No If yes, by whom and how much? _____
   _____
4. Since the first of the year, have you received Part B therapy services in your home? □ Yes □ No
   If yes, by whom and how much? _____
   _____

Previous Home Health

Are you currently receiving home health services for nursing, or physical, occupational or speech therapy, from a home health agency? □ Yes □ No

Signing below indicates that the answers above are true and correct, and that the information is complete to the best of the signor's knowledge.

Patient Signature _____ Witness Signature _____

Date _____ Date _____

LAKE CENTRE for REHAB

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Patient_____

Medicare #_____ Admit/Eval Date_____

Facility_____ Provider #_____

1. Is the patient covered by Veterans Administration or Black Lung? ☐ Yes ☐ No

2. Was illness due to an injury? ☐ Yes ☐ No If yes,

   a. Date of accident_____
   b. What type of accident cause your illness/injury?_____
      _____
   c. Is the patient filing or intending to file a liability suite?_____
      If yes, please give name and address of attorney_____
      _____

3. Is the patient employed (Medicare disabled beneficiaries under the age of 65 or Medicare over the age of 65) and covered by a group health plan? ☐ Yes ☐ No

   a. Date of retirement_____
   b. Is the patient married?_____
   c. Is the spouse currently employed?_____
   d. Does the spouse have group coverage?_____
   e. Does the patient have coverage through a spouse, parent or guardian's employer group health plan?_____

4. Is the patient entitled to benefits solely on the basis of end stage renal disease? ☐ Yes ☐ No Has the patient been undergoing kidney dialysis for more than 12 months? ☐ Yes ☐ No

If you answered yes to any of the above questions, you will need to fill out the information requested below.

Insurance company_____

Address_____

Policy/certificate number_____

Group name_____

Group number_____

PATIENT SIGNATURE_____ DATE_____

RESPONSIBLE PARTY SIGNATURE_____ DATE_____

Relationship to patient_____

Signature of person completing this form_____ Date_____
(If other than the patient)

LAKE CENTRE for REHAB

Acknowledgement of Receipt of Privacy Notice
in Combination with Voluntary Consent

Acknowledgement:

As a patient of Lake Centre for Rehab, I have been provided with its **Notice of Privacy Practices** which describes how medical information about me may be used or disclosed and informs me of my individual privacy rights.

I acknowledge that I have received the **Notice of Privacy Practices** and understand how medical information about me may be used, the duties of Lake Centre for Rehab, and my rights to privacy protection and access to my medical information. I understand that the office manager of Lake Centre for Rehab is available to answer any questions that I may have regarding issues of privacy.

Consent:

I give consent for medical information about me to be used and disclosed for purposes of treatment, payment or health care operations. I understand that the privacy regulations allow Lake Centre for Rehab to use or disclose my medical information for these purposes, and that my consent is not required. Lake Centre for Rehab is obtaining my consent to provide additional assurance regarding the privacy of my medical information.

I understand that I have the right to make a request to revoke this consent and instead request a restriction on the use of my medical information at any time. I further understand that Lake Centre for Rehab may choose not to agree to the request for a restriction on the uses or disclosures of my medical information for purposes of treatment, payment or health care operations.

To make a request to revoke my consent, I must complete and sign a "Request to Restrict Uses and Disclosures of Protected Health Information" form and return it to the office manager at Lake Centre for Rehab. I may obtain a copy of the form from the office manager at the Lake Centre for Rehab location at which I am being treated.

LAKE CENTRE for REHAB

INSTRUCTIONS

Before your first visit, download the patient forms from our website at www.golcr.com/forms

On your first visit, please remember to bring the following:

1. Physician or NPP (Non-Physician Provider) order for therapy.
2. ***Bring the patient forms you filled out***
3. Insurance cards (primary and secondary).
4. Photo ID.
5. Current list of medicines and allergies.
6. Recent reports that you might have, including x-rays, MRI's, surgeries, etc.
7. Loose-fitting, comfortable clothing.
8. Supportive closed-toe shoes.
9. Bring in any adaptive devices currently used, such as braces, canes, walkers, etc.
10. Copy of home health discharge with name and phone number of home health agency if applicable.
11. Notify us of implants and pacemakers (defibrillators).

Due to allergies of staff members and patients, please refrain from strong fragrances.