

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



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

Male 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:

<input type="checkbox"/> Prostatectomy	<input type="checkbox"/> Kegel exercises	<input type="checkbox"/> Hemorrhoid repair	<input type="checkbox"/> Massage therapy
<input type="checkbox"/> Radiation	<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Ostomy pouch	<input type="checkbox"/> Chiropractor
<input type="checkbox"/> Seed implantation	<input type="checkbox"/> Pelvic floor rehab	<input type="checkbox"/> Hemorrhoid cream	<input type="checkbox"/> Acupuncture
<input type="checkbox"/> Cryotherapy	<input type="checkbox"/> Diet/fluid changes	<input type="checkbox"/> High fiber diet	<input type="checkbox"/> Over the counter pain meds
<input type="checkbox"/> Proton therapy	<input type="checkbox"/> Bladder control meds	<input type="checkbox"/> Probiotics	<input type="checkbox"/> Prescription pain meds
<input type="checkbox"/> Lupron/hormones	<input type="checkbox"/> Collagen injections	<input type="checkbox"/> Stool softeners	<input type="checkbox"/> Bladder instillations
<input type="checkbox"/> Greenlight ablation	<input type="checkbox"/> Self-catheterization	<input type="checkbox"/> Constipation meds	<input type="checkbox"/> Urethral/bladder dilation
<input type="checkbox"/> TURP	<input type="checkbox"/> InterStim	<input type="checkbox"/> Anti-diarrheal meds	<input type="checkbox"/> Bladder instillations
<input type="checkbox"/> BCG treatments	<input type="checkbox"/> Artificial sphincter	<input type="checkbox"/> Herbal supplements	<input type="checkbox"/> Nerve injections/blocks
<input type="checkbox"/> Condom catheter	<input type="checkbox"/> Penile clamp	<input type="checkbox"/> Enemas	Other: _____

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:

<input type="checkbox"/> Urodynamics study	<input type="checkbox"/> Video defacography	<input type="checkbox"/> X-ray	<input type="checkbox"/> Digital rectal exam
<input type="checkbox"/> Bladder scan (PVR)	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> CT scan	<input type="checkbox"/> Prostate biopsy
<input type="checkbox"/> Cystoscopy	<input type="checkbox"/> Anal manometry	<input type="checkbox"/> MRI	<input type="checkbox"/> 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 _____

Prostate	<input type="checkbox"/> Enlarged prostate (BPH)	<input type="checkbox"/> Prostate infections	<input type="checkbox"/> Chronic prostatitis	<input type="checkbox"/> Prostate pain
	<input type="checkbox"/> Erectile dysfunction	<input type="checkbox"/> Erectile/ejaculation pain		
	<input type="checkbox"/> Prostate cancer: If so, when were you diagnosed? _____ What was your Gleason score? _____			
	<input type="checkbox"/> Last PSA reading: _____			
Bladder	Sexual Function: <input type="checkbox"/> I'm sexually active			
	<input type="checkbox"/> I'm not sexually active due to: <input type="checkbox"/> My pelvic pain symptoms		<input type="checkbox"/> My other medical problems	
	<input type="checkbox"/> For non-health related reasons		<input type="checkbox"/> My partner's medical problems	
	<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Small bladder capacity	<input type="checkbox"/> Bladder cancer	<input type="checkbox"/> Bladder infections (UTI's)
	<input type="checkbox"/> Overactive bladder	<input type="checkbox"/> Large bladder capacity	<input type="checkbox"/> Interstitial cystitis	<input type="checkbox"/> Painful bladder syndrome
<input type="checkbox"/> Urinary retention	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Other _____		

Bowels	<input type="checkbox"/> Fecal incontinence	<input type="checkbox"/> Ulcerative colitis	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Colon cancer
	<input type="checkbox"/> Constipation	<input type="checkbox"/> Spastic colon	<input type="checkbox"/> Lactose intolerance	<input type="checkbox"/> Anal cancer
	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Gluten intolerance	<input type="checkbox"/> Colostomy/ ileostomy
	<input type="checkbox"/> Irritable bowel syndrome	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Other _____	

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

Surgeries	Age or Year	Medications	For what condition?

Allergies

None
 Latex sensitivity
 Seasonal (pollen/hay fever)
 Bees
 Other _____

Food _____

Medications _____

Review of Systems - Please check if you have you recently had any of these symptoms.

<input type="checkbox"/> Fever/chills	<input type="checkbox"/> Eye pain/redness	<input type="checkbox"/> Stomach pain	<input type="checkbox"/> Tremors
<input type="checkbox"/> Weight change	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Bloody stools	<input type="checkbox"/> Speech changes
<input type="checkbox"/> Fatigue/night sweats	<input type="checkbox"/> Pounding heart	<input type="checkbox"/> Tarry stools	<input type="checkbox"/> Seizures
<input type="checkbox"/> Skin rash/itch	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Loss of consciousness
<input type="checkbox"/> Headaches	<input type="checkbox"/> Calf pain	<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Vertigo/spinning
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Leg swelling	<input type="checkbox"/> Neck/back pain	<input type="checkbox"/> Unsteadiness
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Cough	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Lightheaded
<input type="checkbox"/> Ear pain/discharge	<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Falls	<input type="checkbox"/> Depression
<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Phlegm production	<input type="checkbox"/> Arm/leg weakness	<input type="checkbox"/> Nervous/anxious
<input type="checkbox"/> Sore throat	<input type="checkbox"/> Congestion	<input type="checkbox"/> Lack of coordination	<input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Difficulty walking	<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Double vision	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Difficulty standing up	<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Light sensitive	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Tingling/numbness	<input type="checkbox"/> 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? _____

- During the **daytime**, how often do urinate? Every 30-60 minutes 1-2 hours 2-3 hours 3-4 hours
 More than 4 hours
- 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
- 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 (<input type="checkbox"/> Reg. <input type="checkbox"/> Decaf)					Water				
Tea (<input type="checkbox"/> Reg. <input type="checkbox"/> Decaf)					Milk				
Soda (<input type="checkbox"/> Reg. <input type="checkbox"/> Decaf)					Juice				
Beer/Wine/Liquor					Other _____				

- 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/chores					
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					
Recreational activities					
Exercise activities					
Other _____					

- 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 <i>fills</i>					
Location:	<input type="checkbox"/> Bladder <input type="checkbox"/> Urethra <input type="checkbox"/> Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				
Pain as my bladder <i>empties</i>					
Location:	<input type="checkbox"/> Bladder <input type="checkbox"/> Urethra <input type="checkbox"/> Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				

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 <i>fill</i>					
Location:	<input type="checkbox"/> Rectum <input type="checkbox"/> Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				
Pain as my bowels <i>empty</i>					
Location:	<input type="checkbox"/> Rectum <input type="checkbox"/> Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				

Pelvic Pain Symptoms: None

 My pelvic symptoms **affect my ability** to, OR **I feel worse when I try** to: Check all that apply.

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

Pain Location: Check all that apply.

- | | | | | |
|---------------------------------------|-------------------------------------|-----------------------------------|--|--|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Scrotum | <input type="checkbox"/> Groin | <input type="checkbox"/> Over tight surgical scars | <input type="checkbox"/> Front of hips |
| <input type="checkbox"/> Penis | <input type="checkbox"/> Buttocks | <input type="checkbox"/> Bladder | <input type="checkbox"/> Sides of hips | <input type="checkbox"/> Rectum |
| <input type="checkbox"/> Low back | <input type="checkbox"/> Side/waist | <input type="checkbox"/> Tailbone | <input type="checkbox"/> Back of hips | |
| <input type="checkbox"/> Inner thighs | <input type="checkbox"/> Urethra | | | |

Circle pain severity: No Pain 0__1__2__3__4__5__6__7__9__10 Worst Pain

Pain with sexual activity:

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> I have to <i>interrupt</i> intercourse due to pain. |
| <input type="checkbox"/> I limit the <i>frequency</i> of sexual activity because of my pain. | <input type="checkbox"/> I <i>avoid it</i> altogether due to my pain. Last intercourse attempt: _____ |

 The pain occurs during: During erection During ejaculation

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

 Location: Penis/scrotum 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 _____

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. 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.
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.**

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.

*** 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.

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

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)
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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.

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.