PT Your Way & Advanced Specialty Care
Patient Registration and Authorization Form
Please Print

Today's Date:_____ Diagnosis: _____Date of Birth:_____
Patient Name: First_____ Last_____
Social Security #:_____ Male_____ Female_____ Married___Single___Widowed___
Home Address: _____
City: _____State:_____Zip Code:_____
Phone Numbers: Home: _____ Cell: _____
Work:_____ Email Address:_____
Employer: _____ Occupation: _____

Who can we thank for sending you to PT Your Way? _____
M.D. _____ Friend _____ Insurance Co._____Internet _____ Other_____
Is this treatment related to an auto accident Yes ___ No ____ If YES, Injury Date_____
Have you had any physical/occupational/speech therapy this calendar year? Yes No # of visits_____

Referring Physician: _____ Phone #_____
Primary Care Physician: _____ Phone # _____

Primary Insurance Company:_____
Policy Holder: _____ Policy Holder Date of Birth:_____
Relationship: _____Social Security #_____ Policy Holder Employer: _____

Secondary Insurance Company: _____
Policy Holder: _____Relationship: _____
Policy Holder Date of Birth: _____Social Security #_____

Tertiary Insurance Company: _____Policy Holder:_____
Relationship: _____Policy Holder Date of Birth:_____Social Security #_____

Workman's Compensation Claim # _____Injury Date : _____
Adjuster and Agency_____ Phone # _____

Emergency Contact: _____
Phone # _____Relationship: _____
The undersigned agrees to be ultimately responsible for payment of all charges for services rendered by PT Your Way & Advanced Specialty Care whether or not such services are covered by insurance benefits. The undersigned agrees to reimburse PT Your Way & Advanced Specialty Care for any expenses, including reasonable attorney fees, incurred in connection with the collection of sums due for services performed hereunder.

Patient/Responsible Party Signature: _____ Date: _____

PHYSICAL THERAPY
YOUR WAY
ADVANCED SPECIALTY CARE

Policies and Procedures
Please read and initial each paragraph and sign the last page

We take your health care very seriously and want to provide the highest quality of care possible. Unlike other physical therapy practices, we are proud to offer high quality one-hour individual appointment sessions with a licensed physical therapist. Our unique approach allows exceptional results and a high rate of patient satisfaction.

_____ **(initial) Cancellation Policy:**
We are committed to providing all our patients one-on-one, one-hour appointments. When a patient cancels without giving enough notice, they prevent another patient from being seen. All appointments require at least **48 hours advance notice on a business day** for any **changes or cancellations.** *Business hours are from 7:00am on Monday through 2:00pm on Friday, excluding holiday closures.* **If 48-hour notification is not given, you will be charged $60 for the missed appointment. This amount will be collected directly from your credit card on file.** To cancel a *Monday* or *Tuesday* appointment, please call our office by 2:00 p.m. on *Friday*. If over the weekend you need to cancel a Monday appointment, please leave a message as soon as possible. Text and email cancellations are not valid. Please call the office for ALL appointment cancellations.

_____ (**initial**) **No Show Policy:** If you fail to show up for a scheduled appointment, a **$60 no show fee will be charged to your credit card on file.**

_____ (**initial**) **Same Day Scheduling:** If you no show and/or late cancel **more than twice**, your future appointments will be canceled and you will be placed on **SAME DAY SCHEDULING.** This means you may contact us in the morning of a day you are available to ask for a same day appointment. We will be happy to place you with any therapist who may have an opening.

_____ **(initial) Late Policy**: If you will be late for your scheduled appointment please call and inform us. We will try to accommodate you, however your treatment session time may be reduced in order to remain on time for the courtesy of the next scheduled patient. For patients whose insurance we are billing, **a delay in your arrival or an early departure from your scheduled one-hour session will incur a $20 charge for every 10 minutes you are absent. If you self pay and are late or need to leave early, you will still be charged for your full hour treatment session.**

_____ (**initial**) **We do understand that unforeseen matters of sickness or emergencies occur that you cannot control. Unfortunately we still need to charge for these missed appointments** in order to continue providing one-hour individual appointment sessions. Thank you for your understanding and cooperation.

_____ **(initial) Appointment Reminders:** As a courtesy to our clients, we offer automated reminder phone calls, text messages or emails, **however it is ultimately your responsibility to attend your scheduled appointment.** Please be sure that the phone number or email you have provided us is correct in order to receive these reminder messages.

I prefer to receive appointment reminders by:

Please circle ONE: **Phone Call** **Email** **Text Message** **None**

Please list the appropriate phone number or email: _____

_____ **(initial) Return Check Fee:** If checks are returned from the bank there will be a $20 returned check fee assessed to your account. This amount will be collected directly from your credit card on file.

_____ **(initial) Payment Policy: Insurance Billing**
Copays, coinsurances, and deductibles will be collected at each visit. We require a credit card to be maintained on file for charging any fees determined to be patient responsibility. Your credit card will continue to be charged as your insurance processes, which may occur even after you have been discharged. I hereby agree to pay any and all charges that are not covered by my insurance plan, such as deductible, coinsurance, copayments, dry needling, medical supplies, no show and late cancel fees, or if my insurance plan does not pay for any reason, including exceeding maximum benefits, failure to obtain pre-authorization or denial related to medical necessity. If you have a **secondary or supplemental insurance**, you are responsible for any remaining primary insurance patient liability amounts after your secondary pays. You may still pay for patient responsible charges with cash, check or HSA/FSA cards by presenting these at the front desk **prior** to your treatment to avoid the charges being run on the credit card on file.

_____ **(initial) Payment Policy: Self Pay Patients**
Our self pay fee is $177 for the Evaluation (first) visit and $150 for each follow up visit. Please come prepared to make a payment at each visit. **We require a credit card to be maintained on file** for charging visit fees, medical supplies, no show and late cancel fees. You may still pay for patient responsible charges with cash, check or HSA/FSA cards by presenting these at the front desk **prior** to your treatment. At the end of each treatment session, you will receive an itemized bill that you can submit to your insurance company. Although we are here to assist you with understanding your insurance coverage, **any reimbursement from an insurance company is the responsibility of the patient.**

_____ **(initial) Authorizations:** Some insurance companies require authorization or a referral for physical therapy. Although we will assist you in this matter, ultimately it is your responsibility to understand your insurance benefits. If your insurance does not authorize your visits in a timely manner, we may need to cancel your appointments until authorization is obtained.

_____ **(initial) HIPAA**: I have read and understand that I have rights to a copy of Back In Motion Physical Therapy's HIPAA privacy notice. This notice is available upon request and on our website at www.backinmotionpt.com. I have the right to request restrictions on the use of my information and to revoke my consent at a later date.

_____ **(initial)** I understand that I am solely responsible for the balance due on my account. **As a courtesy, benefits are verified but are NOT A GUARANTEE of payment/coverage.** All claims are subject to review by your insurance company. I agree to pay any unpaid balance due. If your account balance matures to over 120 days and remains unpaid, your account will be sent to collections and we will no longer be able to assist you with the account. Any accounts in default and sent to collections could be assessed attorney fees, court costs and interest of 1% per month. We hope this course of action is unnecessary, however we are required to notify you of this information.

We appreciate your patronage and thank you for trusting us with your physical therapy needs. I have read and fully understand the above policies and procedures of Back In Motion Physical Therapy P.L.C. and agree to these terms.

Signature of Patient/Responsible Party: _____ Date: _____

PHYSICAL THERAPY YOUR WAY

Alexandria & Lorton VA • 571-312-6966

PEDIATRIC HEALTH HISTORY AND SCREENING QUESTIONNAIRE

Patient History and Symptoms

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

Name of parent or guardian completing this form_____

Child's name:_____Prefers to be called _____ Date: _____

Age _____Grade_____Height _____Weight_____

Describe the reason for your child's appointment_____

When did this problem begin? Is it getting better, worse, variable, staying the same, variable? (circle one)

Name and date of child's last doctor visit _____ Date of last urinalysis_____

Previous tests for the condition for which your child is coming to therapy. Please list tests and results_____

_____

_____

_____

Medications	Start date	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

_____

_____

Does your child now have or had a history of the following? Explain all "yes" responses below.

Y/N Pelvic pain
Y/N Low back pain
Y/N Diabetes
Y/N Latex sensitivity/allergy
Y/N Allergies
Y/N Asthma
Y/N Surgeries

Y/N Blood in urine
Y/N Kidney infections
Y/N Bladder infections
Y/N Vesicoureteral reflux Grade ____
Y/N Neurologic (brain, nerve) problems
Y/N Physical or sexual abuse
Y/N Other (please list)_____

Explain yes responses and include dates_____

Does your child need to be catheterized? Y/N If yes, how often? _____

Bladder Habits

1. How often does your child urinate during the day? _____times per day, every _____ hours.
2. How often does your child wake up to urinate after going to bed? _____times
3. Does your child awaken wet in the morning? Y/N If yes, _____ days per week.
4. Does your child have the sensation (urge feeling) that they need to go to the toilet? Y/N
5. How long does your child delay going to the toilet once he/she needs to urinate? (Circle one)

___ Not at all
___ 1-2 minutes
___ 3-10 minutes
___ 11-30 minutes
___ 31-60 minutes
___ Hours

6. Does your child take time to go to the toilet and empty their bladder? Y/N
7. Does your child have difficulty initiating the urine stream? Y/N

8. Does your child strain to pass urine? Y/N
9. Does your child have a slow, stop/start or hesitant urinary stream? Y/N
10. Is the volume of urine passed usually: Large Average Small Very small (circle one)
11. Does your child have the feeling their bladder is still full after urinating? Y/N
12. Does your child have any dribbling after urination; i.e. once they stand up from the toilet? Y/N
13. Fluid intake (one glass is 8 oz or one cup)
    ___ of glasses per day (all types of fluid)
    ___ of caffeinated glasses per day
    Typical types of drinks _____
14. Does your child have "triggers" that make him/her feel like he/she can't wait to go to the toilet? (i.e., running water, etc.) Y/N please list_____

Bowel Habits

15. Frequency of movements: ___ per day __ per week. Consistency: loose__ normal___ hard__
16. Does your child currently strain to go? Y/N_____ Ignore the urge to defecate? Y/N_____
17. Does your child have fecal staining on his/her underwear? Y/N How often?_____
18. Does your child have a history of constipation? Y/N_____How long has it been a problem?___

SYMPTOM QUESTIONNAIRE

1. Bladder leakage (check all that apply)
   ___ Never
   ___ When playing
   ___ While watching TV or video games
   ___ With strong cough/sneeze/physical exercise
   ___ With a strong urge to go
   ___ Nighttime sleep wetting
2. Frequency of urinary leakage-number (#) of episodes
   ___ # per month
   ___ # per week
   ___ # per day
   ___ Constant leakage
3. Severity of leakage (circle one)
   ___ No leakage
   ___ Few drops
   ___ Wets underwear
   ___ Wets outer clothing
4. Bowel leakage (check all that apply)
   ___ Never
   ___ When playing
   ___ While watching TV or video games
   ___ With strong cough/sneeze/physical exercise
   ___ With a strong urge to go
5. Frequency of bowel leakage-number (#) of episodes
   ___ # per month
   ___ # per week
   ___ # per day
6. Severity of leakage (circle one)
   ___ No leakage
   ___ Stool staining
   ___ Small amount in underwear
   ___ Complete emptying
7. Protection worn (circle all that apply)
   ___ None
   ___ Tissue paper / paper towel
   ___ Diaper
   ___ Pull-ups
8. Ask your child to rate his/her feelings as to the severity of this problem from 0-10
   0_____10
   Not a problem Major problem
9. Rate the following statement as it applies to your child's life today
   My child's bladder is controlling his/her life.
   0_____10
   Not true at all Completely true

Patient Last Name:_____ Date:_____

Please identify up to three important activities that you are unable to do or are having difficulty doing as a result of your current injury or problem. Circle the number on the line that best fits your current ability. **0 being UNABLE TO PERFORM ACTIVITY** and **10 being ABLE TO PERFORM ACTIVITY AT THE SAME LEVEL AS BEFORE INJURY OR PROBLEM.**

		UNABLE										ABLE
1.	_____	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
2.	_____	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
3.	_____	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Medical History

Please mark Yes or No for each of the following. Any YES answers please explain.

Cardiovascular System:	**Yes**	**No**	**Explain**
Lightheadedness	___	___	_____
Heart disease	___	___	_____
Pacemaker	___	___	_____
High Blood Pressure	___	___	_____
Chest pains with rest	___	___	_____
Night sweats	___	___	_____
Shortness of breath	___	___	_____
Excessive sweating	___	___	_____
Heartbeat in abdomen when you lie down	___	___	_____
Leg cramps when walking several blocks	___	___	_____
Pulmonary System:			
Difficulty or labored breathing	___	___	_____
Prolonged cough	___	___	_____
Lung/Asthma	___	___	_____
Smoke/tobacco use	___	___	_____

Blood Born Diseases:	**Yes**	**No**	**Explain**
HIV	___	___	_____
West Nile Virus	___	___	_____
Hepatitis A, B or C	___	___	_____
Lyme's Disease	___	___	_____
Gastrointestinal & Urogenital System:			
Diarrhea or constipation	___	___	_____
Abdominal pain	___	___	_____
Pain or difficulty when urinating	___	___	_____
Leak urine w/cough, sneeze or exercise	___	___	_____
Changes in menstruation pattern (female)	___	___	_____
Currently pregnant	___	___	_____

Patient Last Name:_____ Date:_____

Endocrine System:

Unexplained weight loss or gain	___	___	_____
Diabetes	___	___	_____
Thyroid problems	___	___	_____
Easy bruising	___	___	_____

Nervous System/Musculoskeletal

Have you fallen with injury and/or fallen 2 or more times in the past year?	___	___	_____
Dizziness	___	___	_____
Gait or balance disturbances	___	___	_____
Neurological problems/stoke	___	___	_____
Abnormal Numbness, pins, needles	___	___	_____
Muscle weakness	___	___	_____
Headaches	___	___	_____
Changes in vision	___	___	_____
Arthritis /Joint problems	___	___	_____
Night pain	___	___	_____
Trauma	___	___	_____
Morning stiffness	___	___	_____
Prolonged use of corticosteroids	___	___	_____

Integumentary System:

Changes in skin color or nail integrity		___	_____

General:

Cancer	___	___	_____
Surgeries	___	___	_____
Fever/Chills	___	___	_____
Unusual swelling/edema	___	___	_____
Other medical conditions	___	___	_____

Any additional explanations: _____

_____

Appendix B

Dysfunctional Voiding and Incontinence Symptoms Score (DVISS) Questionnaire	
1. Does your child wet during the day?	No (0) Sometimes (3) Always (5)
2. How wet is your child during the day?	Damp underwear (0) damp pants (3) pants soaking wet (5)
3. Does he/she wet the bed?	No (0) 1-2 nights/wk (1) 3-5 nights/week (3) 6-7 nights/wk (5)
4. How wet is your child during the night?	N/A (0) Damp underwear (1) Damp/soak wet bed (4)
5. How many times does your child urinate?	1-7times/day (0) More than 7times/day (1)
6. My child strains during voiding.	No (0) Yes (4)
7. My child feels pain during voiding.	No (0) Yes (1)
8. My child voids intermittently.	No (0) Yes (2)
9. My child needs to go back to the bathroom soon after he/she finishes.	No (0) Yes (2)
10. My child has a sudden feeling of having to urinate.	No (0) Yes (1)
11. My child holds by crossing his/her legs.	No (0) Yes (2)
12. My child wets on the way to the toilet.	No (0) Yes (2)
13. My child does not have a BM daily.	No (0) Yes (1)
Total	_____

Quality of Life

If your child experiences symptoms mentioned above, does it affect his/her family, social or school life?

No = 1 Yes = 2 Seriously affects = 3

Physical Therapy Your Way & Advanced Specialty Care
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YOUR BLADDER LOG INSTRUCTIONS

Why keep your log?

The main purpose of a bladder log is to keep track of how your bladder functions. A log can give your health care provider an excellent picture of your bladder function, habits and patterns. In the beginning, the log is used as an evaluation tool. Later, it will be used to measure progress. Please complete a bladder log every day for 3 consecutive days (preferably 1 school day and 2 weekend days) and bring it with you to your next appointment.

The log plays an important part in your health care provider's ability to understand the problem and provide you with the appropriate, specialized treatment plan. The log will be much more accurate if it is filled it out throughout the day. It can be very difficult to remember at the end of the day exactly what happened in the morning. Do the best that you can if your child is in school during the day. Perhaps enlist the help of a teacher or aide.

Instructions

Column 1 - Type and Amount of Fluid and Food Intake:

Record;
1. The types and amount of fluid drank, (1 cup or ½ cup is OK)
2. The types of food eaten
3. Bedtime and when awakening time, including naps

Column 2 - Amount Voided (Urinated):

Measuring urine in seconds - To measure in seconds begin counting as soon as the urine comes out and stop counting when the urine stops coming out. If one or two more drops come out after that do not count these. If you have difficulty gauging the amount of urine, you may record seconds by counting "one one thousand" while emptying your bladder. Record the number of seconds voided.

Column 3 - Amount of Leakage:
SMALL= drop or two of urine
MEDIUM= wet underwear
LARGE= wet outerwear or floor

Column 4 - Activity with Leakage & Was Urge Present:

Describe the activity associated with the leakage, i.e. coughed, heard running water, sneezed, playing with friends or had a strong urge.

Describe the urge sensation you had to go as:

MILD = first sensation of need to go.

MODERATE = stronger sensation or need.

STRONG = need to get to toilet, move aside!

Column 5 – Bowel Movement Type 1-7 & Strain:
Please record when you had a bowel movement (BM) and the type of BM by referring to the "Choose Your Poo" chart. Also, log if you needed to strain during the BM.

Column 6 – BM Leakage, Type and Activity during the event.
Describe the type of BM leakage by referring to the "Choose your Poo" chart and the record the activity associated with the leakage (i.e., jumping on the playground).

Comments – Special problems. If underwear or clothing change was needed, record at the bottom of the page.

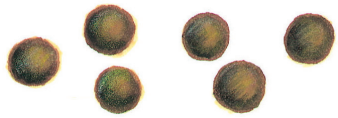
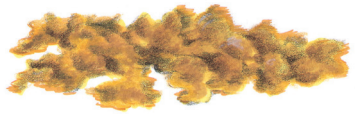
Daily Bladder and Bowel Log

Date: _____

Time Of Day	Type & Amt of Food or Fluid Intake	Amt Voided Seconds	Amt Leakage Sml/Med/Lg	Activity During Urine Leakage Urge Present Y/N	BM Type 1-7 & Time Strain Y/N	BM Leakage Type/Activity Amt: S/M/L
Column1						
12am						
1am						
2am						
3am						
4am						
5am						
6am	Woke up 6:30		LG	Woke up wet		
7am	1/2 c chocolate milk	19 sec				
8am			SML	Recess mod urge		
9am						
10am	apple					
11am						
12pm	Tuna sandwich	16 sec				
1pm	1 cup milk, pear					
2pm			SML	Didn't stop playing		Type 7
3pm	Cookies, 1/2 c milk	11 sec				SM Playground
4pm						
5pm						
6pm	Chicken, corn, salad	9 sec			Type 1 small	
7pm	carrots, apple juice 6oz				Straining	
8pm	Went to bed					
9pm						
10pm						
11pm						
Notes or Comments:						

THE BRISTOL STOOL FORM SCALE (for children)

choose your POO!

type 1		looks like: **rabbit droppings** Separate hard lumps, like nuts (hard to pass)
type 2		looks like: **bunch of grapes** Sausage-shaped but lumpy
type 3		looks like: **corn on cob** Like a sausage but with cracks on its surface
type 4		looks like: **sausage** Like a sausage or snake, smooth and soft
type 5		looks like: **chicken nuggets** Soft blobs with clear-cut edges (passed easily)
type 6		looks like: **porridge** Fluffy pieces with ragged edges, a mushy stool
type 7		looks like: **gravy** Watery, no solid pieces ENTIRELY LIQUID

Concept by Professor DCA Candy and Emma Davey, based on the Bristol Stool Form Scale produced by Dr KW Heaton, Reader in Medicine at the University of Bristol.

Daily Bladder and Bowel Log

Date: _____

Time Of Day	Type & Amt of Food or Fluid Intake	Amt Voided Seconds	Amt Leakage Sml/Med/Lg	Activity During Urine Leakage Urge Present Y/N	BM Type 1-7 & Time	Soiling or BM Accident
Column1						
12am						
1am						
2am						
3am						
4am						
5am						
6am						
7am						
8am						
9am						
10am						
11am						
12pm						
1pm						
2pm						
3pm						
4pm						
5pm						
6pm						
7pm						
8pm						
9pm						
10pm						
11pm						
Notes or Comments:						