

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 #** _____

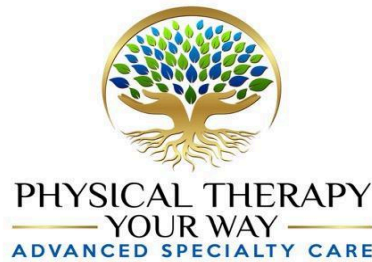
Tertiary Insurance Company: _____ **Policy Holder:** _____
Relationship: _____ **Policy Holder Date of Birth:** _____ **Social Security #** _____

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:** _____



Policies and Procedures

Please read and initial each paragraph and sign the last page

Physical Therapy Your Way & Advanced Specialty Care takes the quality of your health care very seriously. Our model enables us to provide the highest level of specialized care possible. Unlike other physical therapy practices, we are proud to offer one-hour individual appointment sessions with a licensed physical therapist who specializes in treating complex conditions. Our patient centered, holistic approach allows exceptional results and a high rate of patient satisfaction.

_____ (initial) **Payment Policy: SELF PAY Patients**

Our fee is \$186.50 for the Evaluation (first) visit and \$169 for each followup visit. Please come prepared to make a payment at each visit. We accept cash, check and major credit cards. **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) **Payment Policy: INSURANCE Billing**

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. **We require a credit card to be maintained on file for charging any fees determined to be patient responsibility.** You may still pay for patient responsible charges with cash or check prior to your treatment to avoid the charges being run on the credit card on file.

_____ (initial) **Cancellation Policy:**

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 needs to be paid at the time of your cancellation or before your next visit and 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.

_____ (initial) **Late Policy:**

If you think 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. **If you self pay and are late or need to leave early, you will still be charged for your full hour treatment session.** 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.**

_____ (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) **HIPAA:** I have read and understand I have rights to a copy of Physical Therapy Your Way's HIPAA privacy notice. This notice is available upon request and on our website at www.physicaltherapyyourway.net. 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. 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.

Thank you for trusting us with your specialized physical therapy needs. I have read and fully understand the above policies and procedures of Physical Therapy Your Way 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 Blood in urine

Y/N Low back pain

Y/N Kidney infections

Y/N Diabetes

Y/N Bladder infections

Y/N Latex sensitivity/allergy

Y/N Vesicoureteral reflux Grade _____

Y/N Allergies

Y/N Neurologic (brain, nerve) problems

Y/N Asthma

Y/N Physical or sexual abuse

Y/N Surgeries

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

___ 11-30 minutes

___ 1-2 minutes

___ 31-60 minutes

___ 3-10 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

- | | |
|--|---|
| <ol style="list-style-type: none"> 1. Bladder leakage (check all that apply)
 <input type="checkbox"/> Never
 <input type="checkbox"/> When playing
 <input type="checkbox"/> While watching TV or video games
 <input type="checkbox"/> With strong cough/sneeze/physical exercise
 <input type="checkbox"/> With a strong urge to go
 <input type="checkbox"/> Nighttime sleep wetting 2. Frequency of urinary leakage-number (#) of episodes
 <input type="checkbox"/> # per month
 <input type="checkbox"/> # per week
 <input type="checkbox"/> # per day
 <input type="checkbox"/> Constant leakage 3. Severity of leakage (circle one)
 <input type="checkbox"/> No leakage
 <input type="checkbox"/> Few drops
 <input type="checkbox"/> Wets underwear
 <input type="checkbox"/> Wets outer clothing 7. Protection worn (circle all that apply)
 <input type="checkbox"/> None
 <input type="checkbox"/> Tissue paper / paper towel
 <input type="checkbox"/> Diaper
 <input type="checkbox"/> Pull-ups | <ol style="list-style-type: none"> 4. Bowel leakage (check all that apply)
 <input type="checkbox"/> Never
 <input type="checkbox"/> When playing
 <input type="checkbox"/> While watching TV or video games
 <input type="checkbox"/> With strong cough/sneeze/physical exercise
 <input type="checkbox"/> With a strong urge to go 5. Frequency of bowel leakage-number (#) of episodes
 <input type="checkbox"/> # per month
 <input type="checkbox"/> # per week
 <input type="checkbox"/> # per day 6. Severity of leakage (circle one)
 <input type="checkbox"/> No leakage
 <input type="checkbox"/> Stool staining
 <input type="checkbox"/> Small amount in underwear
 <input type="checkbox"/> Complete emptying |
|--|---|
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											
		0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
1.	_____																						
2.	_____																						
3.	_____																						

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/stroke

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 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).

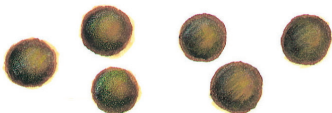




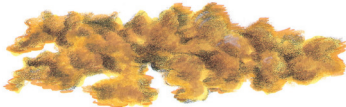

Comments – Special problems. If underwear or clothing change was needed, record at the bottom of the page.

	Daily Bladder and Bowel Log					
Date: _____						
				Activity During	BM Type 1-7	BM Leakage
Time	Type & Amt of Food	Amt Voided	Amt Leakage	Urine Leakage	& Time	Type/Activity
Of Day	or Fluid Intake	Seconds	Sml/Med/Lg	Urge Present Y/N	Strain Y/N	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 DGA Candy and Emma Davey, based on the Bristol Stool Form Scale produced by Dr KW Heaton, Reader in Medicine at the University of Bristol.

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MOVICOL® Paediatric Plain

macrogol 3350, sodium bicarbonate, sodium chloride, potassium chloride

	Daily Bladder and Bowel Log					
Date: _____						
				Activity During		
Time	Type & Amt of Food	Amt Voided	Amt Leakage	Urine Leakage	BM Type 1-7	Soiling or
Of Day	or Fluid Intake	Seconds	Sml/Med/Lg	Urge Present Y/N	& Time	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:						