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: _____

PT Your Way
Patient Health Questionnaire

Date: _____

Patient Name: _____ Height: _____ Weight: _____ Age: _____

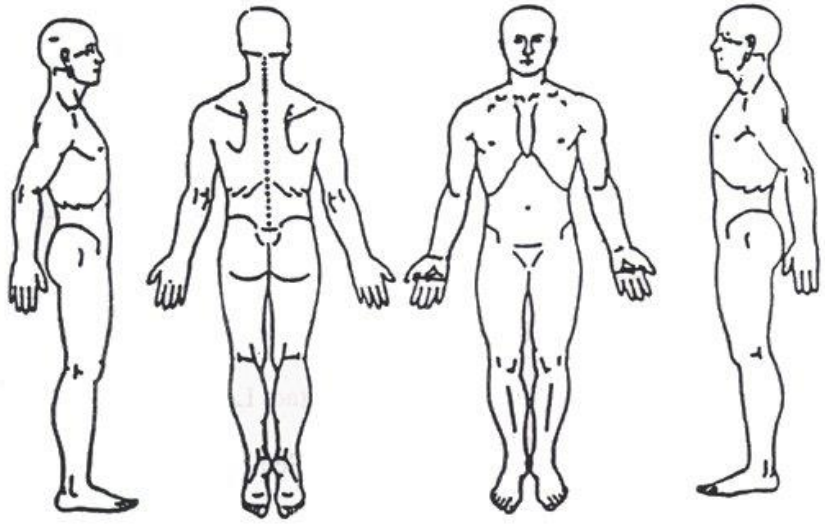
1. Onset of Symptoms/Injury Date_____ Surgery Date (if applicable)_____
2. Describe your symptoms:_____
3. How did your symptoms start or most recently flare-up?_____
   _____
4. During the past week indicate the average intensity of your symptoms on a scale of 0 -10.
   With **0 being NO PAIN** and **10 being UBEARABLE PAIN:** **0 1 2 3 4 5 6 7 8 9 10**

5. During the past week how much has pain interfered with your normal work? (include work outside the house and housework) Please circle:
   Not at all A little bit Moderately Quite a bit Extremely

6. Have your symptoms caused you to stop or limit participation in events such as? please circle**;**
   work church gym recreation other_____
7. How often do you experience your symptoms? Circle: **Constantly Intermittently**

8. What describes the nature of your symptoms? Circle: **Sharp Shooting Stiffness**
   Burning Dull ache Weakness Numb Tingling Off balance

9. How are your symptoms changing? Please Circle **Getting better No Change**
   Getting Worse Fluctuating Unpredictable
10. Have you had similar symptoms in the past? **NO YES If so when_____**
11. Please draw below where you have pain or other symptoms?



Please list your current medications:

_____

_____

_____

_____

_____

_____

_____

12. Who have you seen for your current symptoms? Circle: **Primary Dr. Specialist No One**
Chiropractor Acupuncturist Physical Therapist Masseuse Other_____

13. What tests have you recently had completed for your symptoms?
X-Ray Body part_____ Date_____
MRI Body part_____ Date_____
CT Body part_____ Date_____
Other _____ Date_____

14. What is your current work status? Circle: **Full time Part time Student Retired**
Homemaker Other_____ Occupation (if applicable)_____

15. Are any of the following factors contributing to your current condition? Please circle:
sedentary lifestyle fear avoidance fear of falling vision hearing
memory current home environment alcohol use drugs obesity

16. 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**
Light Headedness		___	___ _____
Heart disease		___	___ _____
Pace Maker		___	___ _____
High Blood Pressure		___	___ _____
Chest paint 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	___	___	_____
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: _____

_____

Pelvic Floor Questionnaire

Bladder Questions

Stress Incontinence: Do you leak of urine when you :

Stand up?	Y	N
Cough, sneeze or laugh?	Y	N
Lift objects	Y	N
Exercise	Y	N

Urge Incontinence: Do you leak of urine:

When you have a strong urge to urinate?	Y	N
On the way to the bathroom?	Y	N
While putting your key in the door?	Y	N
While trying to undress at the toilet?	Y	N
When you hear, see or feel water?	Y	N

Voiding Pattern

Difficulty initiating a urine stream?	Y	N
Difficulty stopping your stream?	Y	N
Pain or burning during urination?	Y	N
Blood in your urine?	Y	N
Do you need to strain to empty your bladder?	Y	N

Fluid Intake:

Water: # cups per day?_____

Bladder Irritants: (coffee, tea, cocoa) # of cups per day? _____

Number of carbonated drinks? _____

Number of acidic drinks/day? _____

Number of alcoholic drinks/week? _____

On average how often do you empty your bladder?

Every hour or less___ Between 1-2 hours ____

Between 2-3 hours ____ Between 3-4 hours ____ > 4 hours ____

I wake up to empty my bladder _____ times per night.

Average yearly urinary tract infections? _____

When did you first experience incontinence? _____

Previous Treatment for incontinence:

Have you done exercise to control urine loss? (ie Kegels) Y N

Has your doctor prescribed medication to treat urine loss Y N

Have you had any surgical procedures to treat urine loss?Y Y N

What type of protective devices do you use? (check all that apply)

Panty liner ___ sanitary pad: mini ____ maxi _____

Incontinence pad or brief ____ # of pads per day? ____

Bowel Habits:

Frequency of BM: ___day ___week

Straining Y N

Do you experience fecal incontinence? Y N

Do you often use laxatives? Y N

How often? _____

Do you use enemas? Y N

How often? _____

Do you include fiber? Y N

Types: _____

Pelvic & Back Pain:

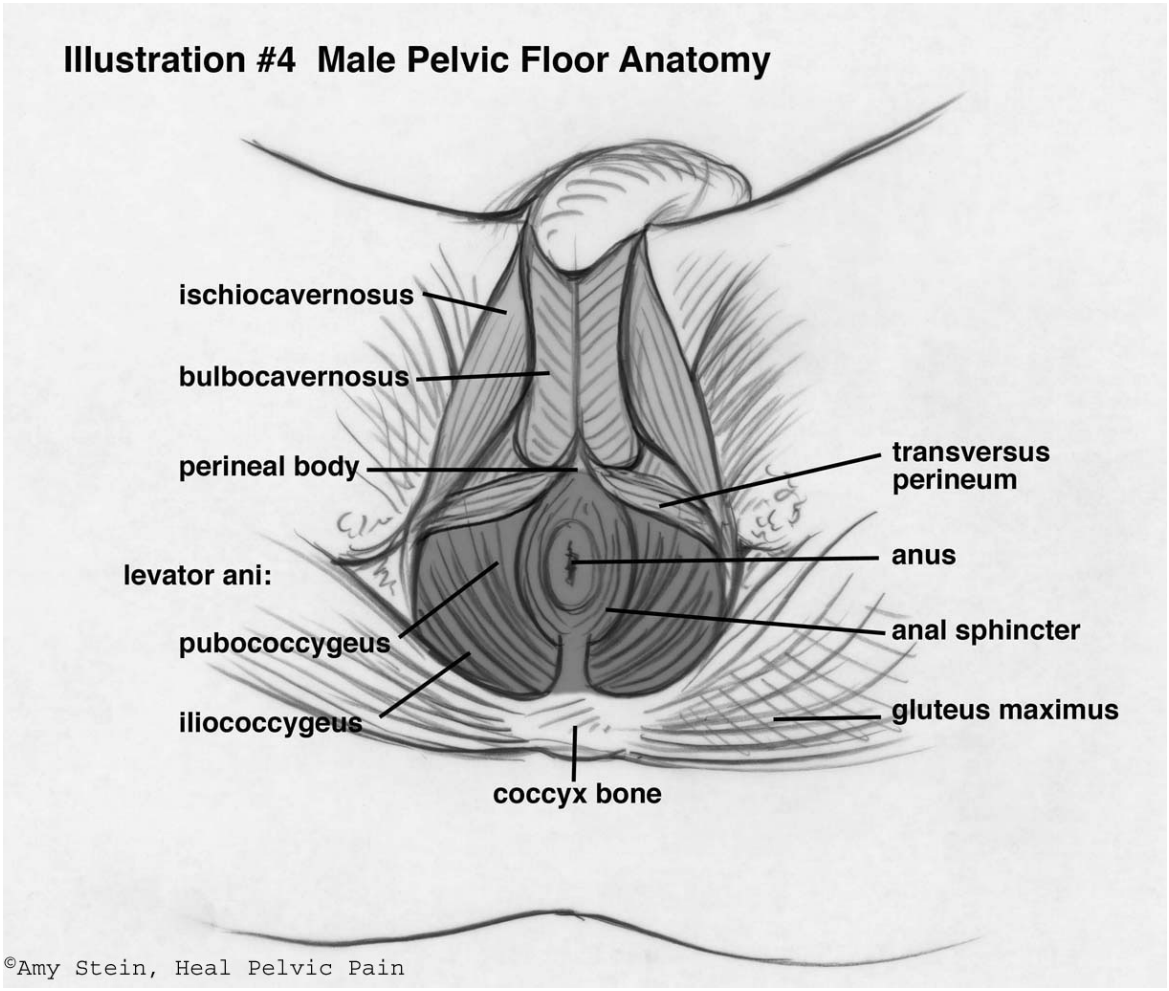
Do you experience pain during sexual relations or intercourse? Y N

Do you experience pain in the lower abdomen or perineum? Y N

Do you experience back pain? Y N

Do you experience heaviness or pressure on your perineum? Y N

Mark with an "x" where you have pain:



NIH-Chronic Prostatitis Symptom Index (NIH-CPSI)

Pain or Discomfort

1. In the last week, have you experienced any pain or discomfort in the following areas?

		Yes	No
a.	Area between rectum and testicles (perineum)	❑1	❑0
b.	Testicles	❑1	❑0
c.	Tip of the penis (not related to urination)	❑1	❑0
d.	Below your waist, in your pubic or bladder area	❑1	❑0

2. In the last week, have you experienced:

		Yes	No
a.	Pain or burning during urination?	❑1	❑0
b.	Pain or discomfort during or after sexual climax (ejaculation)?	❑1	❑0

3. How often have you had pain or discomfort in any of these areas over the last week?

- ❑0 Never
- ❑1 Rarely
- ❑2 Sometimes
- ❑3 Often
- ❑4 Usually
- ❑5 Always

4. Which number best describes your AVERAGE pain or discomfort on the days that you had it, over the last week?

❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
0	1	2	3	4	5	6	7	8	9	10
NO PAIN										PAIN AS BAD AS YOU CAN IMAGINE

Urination

5. How often have you had a sensation of not emptying your bladder completely after you finished urinating, over the last week?

- ❑0 Not at all
- ❑1 Less than 1 time in 5
- ❑2 Less than half the time
- ❑3 About half the time
- ❑4 More than half the time
- ❑5 Almost always

6. How often have you had to urinate again less than two hours after you finished urinating, over the last week?

- ❑0 Not at all
- ❑1 Less than 1 time in 5
- ❑2 Less than half the time
- ❑3 About half the time
- ❑4 More than half the time
- ❑5 Almost always

Impact of Symptoms

7. How much have your symptoms kept you from doing the kinds of things you would usually do, over the last week?

- ❑0 None
- ❑1 Only a little
- ❑2 Some
- ❑3 A lot

8. How much did you think about your symptoms, over the last week?

- ❑0 None
- ❑1 Only a little
- ❑2 Some
- ❑3 A lot

Quality of Life

9. If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that?

- ❑0 Delighted
- ❑1 Pleased
- ❑2 Mostly satisfied
- ❑3 Mixed (about equally satisfied and dissatisfied)
- ❑4 Mostly dissatisfied
- ❑5 Unhappy
- ❑6 Terrible

Scoring the NIH-Chronic Prostatitis Symptom Index Domains

Pain: Total of items 1a, 1b, 1c,1d, 2a, 2b, 3, and 4 = _____

Urinary Symptoms: Total of items 5 and 6 = _____

Quality of Life Impact: Total of items 7, 8, and 9 = _____

The IIEF-5 Questionnaire (SHIM)

Please encircle the response that best describes you for the following five questions:

Over the past 6 months:					
1. How do you rate your confidence that you could get and keep an erection?	Very low 1	Low 2	Moderate 3	High 4	Very high 5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	Almost never or never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?	Almost never of never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Extremely difficult 1	Very difficult 2	Difficult 3	Slightly difficult 4	Not difficult 5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	Almost never or never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5

Total Score: _____

1-7: Severe ED 8-11: Moderate ED 12-16: Mild-moderate ED 17-21: Mild ED 22-25: No ED

Alexandria and Lorton, VA • 571-312-6966

PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

I acknowledge and understand that I have been referred for evaluation and treatment for a pelvic floor dysfunction. Pelvic floor symptoms include, but are not limited to, incontinence of bowel or bladder; difficulty with bowel, bladder, or sexual functions; painful scars after childbirth or surgery; persistent sacroiliac or low back pain; and pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin conditions, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

Treatments may include, but are not limited to, the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization, and educational instruction.

I understand that in order for therapy to be effective, I must attend my scheduled appointments. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

1. The purpose, risks, and benefits of this evaluation have been explained to me.
2. I understand that I can terminate this procedure at any time.
3. I understand that I am responsible for immediately telling the therapist if I am having any discomfort or unusual symptoms during the evaluation.
4. ___ I would like to have a chaperone present in the room during the treatment session.
   ___ I do not wish to have a chaperone present in the room during the treatment session.
   (Please select one)

Date: _____ Patient Name:_____

_____ _____

Patient Signature Signature of Parent or Guardian (if applicable)

_____

Witness Signature