capstone physical therapy

Financial Policy

Deductible $ _____ / $ _____ met

Co-pay/coinsurance _____

Out of pocket $ _____ / $ _____ met

Date Verified: _____

☐ N/A - no patient responsibility

Please carefully review our financial policies to answer any questions you may have regarding your services with us.

- All co-pays are due at the time of service.
- We accept cash, checks, Visa and Mastercard.
- Payment in full may be due at the time of service depending upon services rendered.

Insurance: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you we will bill your insurance provider for the services rendered. Your contract dictates the services that are covered and the amount of payment for those services. You are responsible for payment of services provided, a physician's referral and our verification of insurance does not guarantee payment. Please advise our clinic of any changes or updates in address, insurance, phone, new injury or employment changes to ensure accurate billing.

Medicare Patients: As of January 1,2006 Medicare has a dollar amount cap for outpatient Physical Therapy benefits. Your supplemental plan may provide coverage beyond this cap. It is your responsibility to be aware of the remaining benefits under Medicare. This waiver is an acknowledgement that you are aware of the Medicare cap and that you are responsible for paying the balance on any visits that Medicare or your insurance does not.

Workers Compensation Claims/Self-Insured Claims: Please provide the office the name and phone number of your claims representative before you begin treatment. We request your private insurance information at the time of service. If your L&I claim is not accepted we will bill your private insurance. You are responsible for payment of services rendered if your claim is not accepted.

Motor Vehicle Collisions: We will bill your Personal Injury Protection Insurance (PIP) as a courtesy to you. However, you are fully responsible for the bill. In the event that payment has not been made within 30 days, you will be required to make payment arrangements.

Private Pay/No Insurance: Full payment is due at the time of service.

Doctor Referrals: You are responsible for obtaining a referral and/or prescriptions from your primary care physician prior to your appointment. It is your responsibility to make sure we have a valid and current copy of your referral/prescription in the office at the time of your appointment. Exceptions to this policy are plans that have direct access to therapy with no referral required.

Payment Issues: Please contact our Billing department as soon as possible if financial problems arise. If an account becomes past due, necessary action will be taken, up to and including collections or legal action. The undersigned understands that he/she or his/her agent is responsible for charges incurred.

Cancellations and No Show appointments: If you are unable to make your scheduled appointment we ask that you contact our office to cancel your appointment. If appointments are cancelled with less than 48 hour notice there is a $45 cancellation fee that will be the patient's responsibility.

_____
Initial

I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that the benefits quoted to me are not a guarantee of claim payment. I understand that payment is dependent on my eligibility at the time of service and ALL terms and conditions of my insurance plan. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges.

_____
Initial

I authorize Capstone Physical Therapy to release any necessary information requested by my insurance carrier and authorize payment directly to Capstone Physical Therapy for any benefits available under my insurance plan. I have read and understand the above mentioned and consent to evaluation and treatment. I have carefully read the Financial Policy and agree to the terms therein.

_____ _____ _____

Signature of Patient or Responsible Party *Print Name* *Date*

Pelvic Health History

Name: _____ Height: _____ Weight: _____

Date of last doctor visit: _____ Last urinalysis: _____ Referring Provider: _____

Previous tests or treatments for the condition for which you are coming to physical therapy:

_____

How long ago did the onset of your symptoms occur? _____

Pain Behavior

	None				Moderate								Extreme
What is the worst your pain has been?	0	1	2	3	4	5	6	7	8	9	10		
What is your current pain?	0	1	2	3	4	5	6	7	8	9	10		
What is the best your pain has been?	0	1	2	3	4	5	6	7	8	9	10		

Pain Description: ☐Aching/Dull ☐ Burning ☐ Sharp ☐Throbbing ☐ Consistant

Do you now have or have you had a history of the following?

- ☐ Coronary artery disease
- ☐ High Blood Pressure
- ☐ Headaches
- ☐ Pacemaker/ Nitroglycerin patch
- ☐ Heart trouble/angina
- ☐ Frequent falls
- ☐ Dizziness
- ☐ Blackouts
- ☐ Poor Circulation
- ☐ Epilepsy/seizures
- ☐ Diabetes
- ☐ Cancer/tumors
- ☐ Thyroid problems
- ☐ Osteoporosis
- ☐ Severe pain at night
- ☐ Night sweats
- ☐ Fatigue
- ☐ Smoking/Tobacco use
- ☐ Alcohol use
- ☐ Unexplained weight loss
- ☐ Unexplained weight gain
- ☐ Abdominal pain
- ☐ Pelvic pain
- ☐ Pain with climbing stairs
- ☐ Yeast infections
- ☐ Sexual abuse
- ☐ Sexually transmitted diseases
- ☐ Trouble achieving orgasm
- ☐ Childhood bladder problems
- ☐ Bladder infections
- ☐ Painful urination
- ☐ Painful bowel movements
- ☐ Trouble emptying bladder
- ☐ Trouble emptying bowel
- ☐ Trouble feeling bladder urge/fullness
- ☐ Dribbling of urine
- ☐ Slow urine stream
- ☐ Fecal incontinence
- ☐ Constipation
- ☐ Trouble holding back gas
- ☐ Gastrointestinal problems
- ☐ Blood in stool
- ☐ Irritable bowel syndrome
- ☐ Inflammatory bowel disease

Females only

_____ # of pregnancies
_____ # vaginal delivery
_____ # C-section

- ☐ Painful penetration/intercourse
- ☐ Vaginal dryness
- ☐ Painful menstrual cycles
- ☐ Irregular menstrual cycles
- ☐ Menopause: Date of last period _____
- ☐ Difficult childbirth/miscarriage
- ☐ Pelvic infections/inflammatory disease
- ☐ Fibroids/Cysts
- ☐ Endomentriosis
- ☐ Pelvic exam (PAP) within the last 12 months Date:_____
- ☐ Mammogram or breast exam within the last 12 months Date:_____
- ☐ Currently or possibly pregnant Due Date:_____

Males only

- ☐ Erectile dysfunction
- ☐ Prostate disorders
- ☐ Shy bladder
- ☐ Painful ejaculation
- ☐ Prostate exam within the last 12 months Date:_____

Pelvic Health History Page 2

What are your goals with therapy? _____

_____

Other complaints or concerns?_____

_____

Please list all pelvic or abdominal surgeries and their dates: _____

_____

_____

Please indicate type of protection used:

( ) None ( ) Tissue/Paper Towels ( ) Panty Liner ( ) Medium Flow Pad

( ) Heavy Flow Pad ( ) Specialty Pad/Protective Garment

Number of bowel/urine leakage accidents per 24 hours? _____

Frequency of daytime urination? _____

Frequency of nightime urination? _____

Authorization to Treat

I authorize the therapists of Capstone Physical Therapy to administer such treatment as is prescribed and considered therapeutically necessary on the basis of findings during the course of treatment. The information provided is accurate to the best of my knowledge. 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.

_____

Signature *Date*

Pelvic Floor Disability Index (PFDI-20)

Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, **how much they bother you**. Answer these by circling the appropriate number. While answering these questions, please consider your symptoms over the last 3 months. The PFDI-20 has 20 items and 3 scales of your symptoms. All items use the following format with a response scale from 0 to 4.

Symptom scale:

0 = not present
1= not at all
2 = somewhat
3 = moderately
4 = quite a bit

Pelvic Organ prolapse Distress Inventory 6 (POPDI-6)

Do You…	**NO**	**YES**
1. Usually experience pressure in the lower abdomen?	0	1 2 3 4
2. Usually experience heaviness or dullness in the pelvic area?	0	1 2 3 4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1 2 3 4
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1 2 3 4
5. Usually experience a feeling of incomplete bladder emptying?	0	1 2 3 4
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1 2 3 4

Colorectal-Anal distress Inventory 8 (CRAD-8)

Do You…	**NO**	**YES**
7. Feel you need to strain too hard to have a bowel movement?	0	1 2 3 4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1 2 3 4
9. Usually lose stool beyond your control if your stool is well formed?	0	1 2 3 4
10. Usually lose stool beyond your control if your stool is loose?	0	1 2 3 4
11. Usually lose gas from the rectum beyond your control?	0	1 2 3 4
12. Usually have pain when you pass your stool?	0	1 2 3 4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1 2 3 4
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1 2 3 4

Urinary distress Inventory 6 (UDI-6)

Do You…	**NO**	**YES**
15. Usually experience frequent urination?	0	1 2 3 4
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	0	1 2 3 4
17. Usually experience urine leakage related to coughing, sneezing or laughing?	0	1 2 3 4
18. Usually experience small amounts of urine leakage (that is, drops)?	0	1 2 3 4
19. Usually experience difficulty emptying your bladder?	0	1 2 3 4
20. Usually experience pain or discomfort in the lower abdomen or genital region?	0	1 2 3 4

Scoring the PFDI-20

Scale Scores: Obtain the mean value of all of the answered items within the corresponding scale (possible value 0 to 4) and then multiply by 25 to obtain the scale score (range 0 to 100). Missing items are dealt with by using the mean from answered items only.

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Medications & Allergies

Please list ALL medications (including prescription, over-the-counter, herbals, vitamins, minerals, dietary or nutritional supplements) which you may be taking routinely and / or on as needed basis.

If you have too many medications to list on this page or are not sure about the details, we can call your primary care doctor for an extensive list. Please inform the patient care coordinator at your clinic if this is the case.

	Medication	Dosage	Times Per Day	Route (oral, injection, etc)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

Allergies

Please list any allergies: _____

_____

_____

_____

Signature: _____ Date: _____

This information has been reviewed with the patient/guardian to confirm accuracy. Therapist Initals: _____

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Notice of Privacy Practices

Acknowledgement of Receipt

Check one box:

☐ I acknowledge being offered a copy of the Notice of Privacy Practices and have chosen to take a copy for my personal records.

☐ I have been offered a copy of the Notice of Privacy Practices for Capstone Physical Therapy, but I have chosen to decline a copy at this time.

Communication Preferences

Check all that apply:

☐ In addition to those described in the Privacy Policy, I give my permission for CPT to discuss my health care and billing information with the following people:

Name_____ Relationship_____
Name_____ Relationship_____
Name_____ Relationship_____

☐ Phone: I give CPT permission to leave a detailed message on my voicemail/ answering machine.

☐ Email: I give CPT permission to send me email messages regarding my care, educational newsletters and upcoming clinic events. (*We will not sell or distribute your email address to any other entity.*)

Email address: _____

_____

Patient or Guardian Signature Print Name Date

How did you hear about us? - Circle any that apply

Primary Care Physician Specialist Family Friend Radio Other - specify below

Thank you for choosing Capstone Physical Therapy!