



Financial Policy

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. Payment in full may be due at the time of service depending upon services requested.
- We accept cash, checks, & credit cards.

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. Please advise our clinic of any changes or updates in address, insurance, phone, new injury or employment changes to ensure accurate billing.

- **Medicare:** As of January 1, 2006, Medicare has a dollar amount soft cap for outpatient Physical & Occupational Therapy benefits. If you have a supplement plan, it may provide coverage beyond this cap.
- **Workers Compensation Claims:** Please provide the office the name and phone number of your claims representative before your begin treatment. We require your private information at the time of service. If your claim is not accepted, we will bill your private insurance.
- **Motor Vehicle Collisions:** We will bill your Personal Injury Protection (PIP) as a courtesy to you. However, you are fully responsible for the bill. We require your private information at time of service and will bill your insurance in the event that payment has not been made within 60 days.
- **Private Pay/No Insurance:** Full payment is due at the time of service.

Doctor Referrals: 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.

High Deductibles: If your insurance plan requires you to meet your deductible before it will cover your visit, Capstone will collect a \$120 payment up front towards the visit amount. Estimated visit costs range between \$120 - \$250 depending on insurance plans and what services are provided.

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 canceled with less than 24-hours notice, there is a \$55 cancellation fee that will be your 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.

Patient balances are due upon receipt of statement. Unpaid balances older than 30 days will have a 10% interest rate applied.

Initial

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.

Notice of Privacy Practices

I have been offered a copy of the Notice of Privacy Practices.

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: _____ Contact Info: _____

Name: _____ Relationship: _____ Contact Info: _____

Name: _____ Relationship: _____ Contact Info: _____

I give CPT permission to leave/send detailed messages regarding my care: ☐ Voicemail ☐ Email

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 Notice of Privacy Practices and agree to the terms therein.

Signature of Patient or Responsible Party

Print Name

Date

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 | ☐ Severe pain at night | ☐ Bladder infections |
| ☐ High Blood Pressure | ☐ Night sweats | ☐ Painful urination |
| ☐ Headaches | ☐ Fatigue | ☐ Painful bowel movements |
| ☐ Pacemaker/ Nitroglycerin patch | ☐ Smoking/Tobacco use | ☐ Trouble emptying bladder |
| ☐ Heart trouble/angina | ☐ Alcohol use | ☐ Trouble emptying bowel |
| ☐ Frequent falls | ☐ Unexplained weight loss | ☐ Trouble feeling bladder urge/fullness |
| ☐ Dizziness | ☐ Unexplained weight gain | ☐ Dribbling of urine |
| ☐ Blackouts | ☐ Abdominal pain | ☐ Slow urine stream |
| ☐ Poor Circulation | ☐ Pelvic pain | ☐ Fecal incontinence |
| ☐ Epilepsy/seizures | ☐ Pain with climbing stairs | ☐ Constipation |
| ☐ Diabetes | ☐ Yeast infections | ☐ Trouble holding back gas |
| ☐ Cancer/tumors | ☐ Sexual abuse | ☐ Gastrointestinal problems |
| ☐ Thyroid problems | ☐ Sexually transmitted diseases | ☐ Blood in stool |
| ☐ Osteoporosis | ☐ Trouble achieving orgasm | ☐ Irritable bowel syndrome |
| | ☐ Childhood bladder problems | ☐ 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
☐ Endometriosis
☐ Pelvic exam (PAP) within the last 12 months
☐ Mammogram or breast exam within the last 12 months
☐ Currently or possibly pregnant

Males only

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

Date: _____

Date: _____

Date: _____

Due Date: _____

Name: _____ Height: _____ Weight: _____

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

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 nighttime urination? _____

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

☐ Endometriosis

☐ Pelvic exam (PAP) within the last 12 months

☐ Mammogram or breast exam within the last 12 months

☐ Currently or possibly pregnant

Males only

☐ Erectile dysfunction

☐ Prostate disorders

☐ Shy bladder

☐ Painful ejaculation

☐ Prostate exam within the last 12 months

Date: _____

Date: _____

Date: _____

Due Date: _____

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)

<i>Do You...</i>	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)

<i>Do You...</i>	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)

<i>Do You...</i>	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.

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 Initials: _____

CONSENT TO USE ARTIFICIAL INTELLIGENCE SCRIBE TECHNOLOGY

Patient Name: _____

Date of Birth: _____

I acknowledge that _____ Clinic ("Provider") will be using an artificial intelligence (AI) scribe software service ("Software") during my physical therapy visits. This Software will create notes in real-time, allowing my Provider to focus on me and less time on documenting our therapy encounter.

By initialing and signing this **Consent to Use Artificial Intelligence (AI) Scribe Technology Form**, I expressly certify that I understand:

- _____ 1. Provider will be using the Software service to capture conversations between Provider and myself to auto-generate Provider's documentation and administrative work.
- _____ 2. The Software will process an audio recording of the conversation between Provider and me and will record my protected health information to auto-generate Provider's draft note.
- _____ 3. The provider will use the draft note to document and sign the final note that becomes part of my electronic medical record.
- _____ 4. The audio recording will be stored securely after Provider has finalized and signed the note and transferred it to my electronic medical record. The audio recording will be stored in accordance with the security regulations of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").
- _____ 5. The audio recording of my protected health information will be used for clinical purposes, only, which includes treatment, payment, or health care operations in accordance with HIPAA. It will not be used for any other purposes.
- _____ 6. I may revoke this Consent at any time by giving written notice to Provider, except to the extent that Provider and its agents, employees, and representatives may have taken prior action in reliance on this Consent.

I have read all the information above, or it has been read to me. I have had the opportunity to ask questions about the Software, and any questions I have asked have been answered to my satisfaction. By initialing the above statements and signing below, I expressly consent to use the Software and to have my visits recorded to support my Provider's clinical work.

Patient Signature

Date

Parent/Legal Guardian (If Patient is a Minor)