INNOVA
PHYSICAL THERAPY TRANSFORMED

Patient Information (Please Print)

First Name _____ MI _____ Last Name _____ DOB _____

Address _____ City _____ State _____ Zip _____

Phone ( ) _____ Email: _____
FOR BILLING QUESTIONS/ CONCERNS/ INVOICES/ UPDATES

How do you want to receive appointment reminders? Select 1: ☐ Text ☐ Phone Call ☐ Email
Sex (*required for insurance purposes*): ☐ Male ☐ Female
Gender if different from sex (*optional*): ☐ Transgender ☐ Gender Fluid ☐ Non-Binary ☐ Other _____
Pronoun Preference (*optional*): ☐ he/ him/ his ☐ she/ her/ hers ☐ they/ them/ theirs ☐ Other _____
Who may we thank for referring you? Please Indicate Whom _____

Emergency Contact (Please Print) REQUIRED

Name _____ Phone ( ) _____ Relationship _____

Problem

Referring Provider _____ Primary Care Physician _____

Injury/ Body Part Involved _____ ☐ Right ☐ Left

Last MD Visit _____ Have you previously been treated by a Physical Therapist this year? ☐ Yes ☐ No

Insurance Information REQUIRED

Primary Insurance _____ (REQUIRED) Secondary Insurance _____ (REQUIRED or indicate none N/A)

Subscriber Name _____ (REQUIRED) Subscriber Name _____ (REQUIRED or indicate none N/A)

Subscriber DOB _____ (REQUIRED) Subscriber DOB _____ (REQUIRED or indicate none N/A)

Relationship to Subscriber _____ (REQUIRED) Relationship to Subscriber _____ (REQUIRED or indicate none N/A)

ID # _____ (REQUIRED) Group # _____ (REQUIRED) ID # _____ (REQUIRED or indicate none N/A) Group # _____ (REQUIRED or indicate none N/A)

☐ I am not providing insurance information. I am private paying for my sessions.

Work Related Injury or Motor Vehicle Accident

☐ Work Related ☐ MVA Claim No. _____ Date of Injury _____

Insurance Name _____ Insurance Billing Address _____

Claim Manager's Name _____ Phone ( ) _____

☐ **This is not work or accident related**

Agreement

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of service and I am financially responsible for non-covered services. I also authorize Innova Physical Therapy to release any information to referring/consulting physicians or other health care providers as deemed appropriate to facilitate my/our care.

Signature (Parent/ Guardian if patient is a minor) _____ Date _____

Name: _____
Height: _____
Weight: _____

PELVIC FLOOR INTAKE FORM

Describe the current problem that brought you here: _____

_____

When did your problem first begin? _____
Was your first episode of the problem related to a specific incident? Yes/No
If so, please describe and specify date _____
Please check the appropriate box to describe the level of pain/ discomfort you are having today.
0= No pain 10=Worst pain imaginable

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Please describe the timing of your pain:

☐Constant ☐Comes and Goes ☐Getting Worse ☐Getting Better ☐Keeps Me Awake

Do you have pain with:

Y/N	Tampon Use	Y/N	Valsalva	Y/N	Bowel Movement
Y/N	Pelvic exams	Y/N	Coughing/sneezing	Y/N	Urination
Y/N	Intercourse	Y/N	Jumping/running	Y/N	Urge (bowel or bladder)

What relieves your symptoms? _____
Have you received treatment for your current condition? ☐Yes ☐No

☐Physical Therapy ☐Massage Therapy ☐Chiropractic ☐Acupuncture

How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify_____
Diet /Fluid intake, specify _____
Physical activity, specify _____
Work, specify _____
Other _____

What are your treatment goals/concerns?_____

Since the onset of your current symptoms have you had:

Y/N	Fever/Chills	Y/N	Malaise (Unexplained tiredness)
Y/N	Unexplained weight change	Y/N	Unexplained muscle weakness
Y/N	Dizziness or fainting	Y/N	Night pain/sweats
Y/N	Change in bowel or bladder functions	Y/N	Numbness / Tingling

Health History
Date of Last Physical Exam _____ Tests performed_____
Date of Last Pap smear _____Tests performed_____

General Health: Excellent Good Average Fair Poor
Occupation _____Hours/week_____ On disability or leave?_____
Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week
Describe _____
Activity Restrictions? _____

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Please circle as many of the following conditions that apply to you and describe if necessary:

Allergies – list below
Alcoholism/Drug Problems
Anemia
Anorexia/bulimia
Anxiety
Arthritic Conditions
Asthma
Cancer
Chronic Fatigue Syndrome
Depression
Diabetes
Epilepsy/seizures
Fibromyalgia
Headaches
Head injury/trauma
Hearing loss/problem
Heart problems
Hepatitis
High blood pressure
HIV/AIDS
Hypothyroid/hyperthyroid
Irritable Bowel Syndrome
Kidney Disease
Latex Sensitivity
Multiple Sclerosis
Musculoskeletal pain
Osteoporosis/osteopenia
Raynaud's (cold hands and feet)
Sexually transmitted disease
Sports Injuries
Stroke
TMJ/neck pain
Unusual stress at home/work
Vision/eye problems
Pelvic Health Related:
Amenorrhea
Childhood bladder issues
Coccyx fracture/injury
Dysmenorrhea
Endometriosis
Fibroids
Interstitial Cystitis
Menopause- when? ____
Pelvic Congestion
Physical or Sexual Abuse
Pudendal Neuralgia
Vestibulitis
Vulvodynia
Other/Describe _____

OB History

Y/N Pregnancies # ___
Y/N Vaginal deliveries #___
Y/N C-section #___
Y/N Trouble healing after delivery
Y/N Episiotomy or Tears
Y/N Prolapse or organs falling out
Y/N Pelvic pain
Y/N Other/describe: _____

GYN History

Y/N Sexually active
Y/N Pain with vaginal penetration
Y/N Use of Birth Control or Protection
Y/N Sexual abuse or trauma
Y/N Menses – Age of onset ____
Y/N Pain with ovulation or menses
Y/N Regular cycles
Y/N Frequent UTIs

Have you had any of the following tests:
☐Bone Scan ☐MRI ☐XRAY ☐EMG ☐CT Scan ☐Blood Work ☐Injections

Other:_____

Prior Surgery: REQUIRED *If none, indicate N/A*

TYPE	DATE

Medications: REQUIRED *If none, indicate N/A*

NAME	DOSAGE	REASON FOR TAKING

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Pelvic Symptom Questionnaire

Bladder Symptoms

Daily fluid intake (1 glass is 8 oz or 1 cup) _____ glasses per day.
Of this total, how many glasses are caffeinated? _____ glasses per day.
Urinary frequency: _____ times per day, and _____ times per night.
Is your bladder urge: _____ strong, _____ medium, _____ small, _____ absent?
When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
_____ minutes, _____ hours, or _____ not at all.
Do you leak urine when you (circle all that apply): cough/sneeze, laugh, exercise, run, jump, lift, feel cold, have intercourse, or with triggers (hear running water, putting keys in door, or others)?

Y/N Do you wet your bed?
Y/N Do you have pain or burning with urination?
Y/N Do you have difficulty starting a stream?
Y/N Do you strain to empty your bladder?
Y/N Do you feel unable to fully empty?
Y/N Do you have a feeling of "falling out"?
Y/N Do you have leakage with urgency?
Y/N Do you restrict your fluid intake?

Do you use a form of leakage protection? ___ adult/maxi pad, ___ mini pad, ___ pantyliner
If yes, how often do you change your pad? _____ times per day.

Bowel Symptoms

Frequency of bowel movements: _____ times per day, _____ times per week, or _____.
Most common stool consistency? ____ liquid, ____ soft, ____ firm, ____ pellets, ____ other, please describe.
If you have constipation, do you have techniques to manage these symptoms? If so, please describe: _____
_____
When you have a normal urge to have a bowel movement, how long can you delay before you have to go to the toilet? _____ minutes, _____ hours, or _____ not at all.

Y/N Do you have a strong urge to move your bowels?
Y/N Do you strain to have a bowel movement?
Y/N Do you have pain with bowel movements?
Y/N Do you leak or stain feces?
Y/N Do you have diarrhea often?
Y/N Do you include fiber in your diet?
Y/N Do you take laxatives or use enemas regularly?

Intimacy Symptoms

Y/N Are you sexually active? If not, do you avoid intimacy because of pain? Y/N
Y/N Pain with vaginal penetration: Deep or Initial?
Y/N Do you tolerate manual sex?
Y/N Do you tolerate oral sex?
Y/N Do you need to use lubrication?
Y/N Do you have orgasms?
Y/N Pain with orgasm
Y/N Post-coital pain (after intercourse)

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PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence; difficulty with bowel, bladder, or sexual functions; painful scars after childbirth or surgery; persistent sacroiliac or low back pain; or 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 musculoskeletal examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, 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.

Treatment may include, but not be 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 come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. 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 the procedure at any time.
3. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation.
4. **I have the option of having a second person/chaperone present in the room during the procedure and I (please check one of the following options)**

☐ **choose to have second person/chaperone present**

OR

☐ **decline to have a second person/chaperone**

Patient may be required to supply their own second person/chaperone.
Innova will supply when possible.

Date: _____ Patient Printed Name: _____

Signature (Parent or Guardian if patient is a minor): _____

Witness Signature: _____

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FINANCIAL POLICY

Standard Insurance Policy:

Innova will bill your insurance carrier as a courtesy to you. However, you are ultimately responsible for payment for services you receive. If we are contracted with your insurance company, we must follow our contract and their requirements. **It is the insurance company that makes the final determination of your eligibility.**

Costs you may be responsible for after insurance processes:
Deductible
Copayments
Non-Covered Services

If your insurance company requires a referral, you are responsible for obtaining it. Failure to obtain the referral may result in a lower payment from the insurance company. Referrals are current for 90 days unless otherwise specified.

Copays are due at the time of service. It is your responsibility to know the amount of your copay. My copay is $.

The balance on your monthly statement is due and payable when the statement is issued, and is past due if not paid by the due date on the statement. Payment plans are available upon request.

Self-Pay Policy:

Innova will apply a discount for patients without insurance coverage, or for those patients that have exceeded insurance benefits. Payment is due at the time services are rendered.

Auto PIP/ Third Party Policy:

We do not accept third-party or accident settlement *liens.* If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. We require that you allow us to bill your health insurance or pay our self-pay rates at the time of service.

Cancellation Policy:

The appointments made for you represent a time set aside specifically for you and your therapist. We value your time and ask that you value ours by giving at least 24 hours' notice for any cancellations or changes to your appointment.

Patients who fail to provide **24 hours' notice** will be charged a **$60.00 fee**. This fee is not billable to insurance and is due at your next scheduled appointment. Patients who cancel or no show on three separate occasions will be discharged from physical therapy and removed from the schedule. In the event that you are discharged from our care, your referring provider or case manager will be notified of the reason for discharge.

If you have any questions regarding this policy, please do not hesitate to contact our *Clinic Director* at: (425) 658-4980

I understand the Financial Policies as described above. I acknowledge that I am financially responsible for any balance due on covered or non-covered services.

Signature (Parent/ Guardian if patient is a minor) _____ Date _____

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PATIENT ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Information Portability and Accountability Act (HIPAA). I have been given the right to review and receive a copy of Innova's Notice of Privacy Practices. I understand that Innova Physical Therapy will use or disclose my health information for treatment, billing and healthcare operation. I understand that I have the right to request in writing how my private information is used or disclosed.

Signature
(Parent/ Guardian if patient is a minor) _____ Date _____