IN BALANCE PHYSICAL THERAPY

21 CROSSROADS DR, STE 210 OWINGS MILLS, MD 21117

443-948-6609

Patient Registration Form

First Name: ____________________ Last Name: ____________________ MI: ______
Date of Birth: ____________________ Age: ________ Marital Status: ___________
Height: _________ Weight: _________ Occupation: ___________________________
Street Address: ____
City: ____________________________ State: ____________ Zip Code: ____________

E-mail Address: ____

Home Phone: ________________________ Cell phone: ___________________________

Cell phone carrier: __________ Please initial for reminder calls: ___________ (circle: text/email)

Emergency Contact _________________ Phone: _____________ Relationship: _______

Family Physician: ___________________ Location (City, State):___________________
Referring Physician: _________________ Location (City, State):___________________

Would you please tell us how you found our office? (check all that apply)

☐ Doctor Referral ☐ Friend/Family Member ☐ Insurance Company

☐ Internet Search ☐ Other (please explain): _________________________

Policy Acknowledgements : My signature below serves as my confirmation of having read and understood the following policies: (Please check)

- ☐ Condition and Consent for Evaluation and Treatment
- ☐ HIPAA Notification
- ☐ Financial Policy

____ ___________________________

Patient Name (Print) Date

____________________________________ ___________________________

Patient Signature Signature of Guardian (if applicable)

CONSENT

Condition and Consent for Evaluation and Treatment of Pelvic Floor Dysfunction

I acknowledge and understand that I have been referred to In Balance Physical Therapy & Pelvic Health, LLC 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, and vulva 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 muscle examination. This examination is performed by observing and 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. I understand that this evaluation and/or treatment could potentially elicit pain or discomfort. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

Your physical therapist is female. No chaperone will be provided during your physical therapy evaluation and treatment sessions unless you request a chaperone to be present. You may choose to bring a friend or family member during the physical therapy evaluation or treatment at any time.

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 no guarantees have been or can be provided regarding the success of therapy. I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists and therapy assistants and technicians of In Balance Physical Therapy & Pelvic Health, LLC.

Conditions:

In order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of $50.

____ Patient Signature

____ Patient Name (Please Print)

____ Signature of Parent or Guardian (If applicable)

Assignment of Benefits

By signing below you are verifying your consent to allow your insurance carrier to make payments directly to In Balance Physical Therapy at 21 Crossroads Drive, Ste 210, Owings Mills, MD 21117 for all services rendered at the same location. You are also confirming that you have are aware that the verification of benefits is not a guarantee of payment by your insurance carrier and any claims unpaid by your insurance become your responsibility.

_______________________________________ Patient's Signature Date_______________

In Balance Physical Therapy Authorization for Use, Disclosure or Release of Protected Health Information and/or Medical Records

I hereby request and authorize the use, disclosure and/or release by In Balance Physical Therapy and its employees of medical records and/or medical information, including my social security number (if I gave it at admission) or other protected health information as described below:

Patient's name: _______________________________________ Date of Birth: _______________
Patient's address: _______________________________________ Patient's Phone #: _______________

Please identify who is to receive the medical records or other health information that may be used or released:
____

Please describe specifically what medical records or other health information may be used or released:
____

Unless the "No" box is marked, this Authorization extends to such psychiatric, mental health, and drug and alcohol abuse treatment information, if any, as may be contained in said medical record including information protected by I.C. 16-39-1-9, I.C. 16-39-2-1 through 16-39-4-2 and I.C. 16-41-8-1. This release permits re-disclosure in accordance with 42 C.F.R., Part 2, which is a federal regulation governing release and use of medical information pertaining to treatment for alcohol and drug abuse. ☐ NO

Unless the "No" box is marked, the Authorization also extends to information regarding communicable diseases, including human immunodeficiency virus (HIV), and AIDS related complex (ARC) and acquired immunodeficiency syndrome (AIDS), if contained in said medical record. ☐ NO

I understand that upon release and disclosure of the protected medical records and information, the records and information may by subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

I understand that In Balance Physical Therapy will not deny treatment or eligibility for benefits based upon whether I sign this authorization. I also understand that an authorization may be necessary in order to process any request I have made for a release of medical records or other medical information. I may inspect or copy any information used or disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by mailing or delivering a written revocation to In Balance Physical Therapy. The revocation will be effective upon receipt by In Balance Physical Therapy, except to the extent that In Balance Physical Therapy has taken action in reliance on this authorization. I further understand that this authorization will expire sixty (60) days from the Signature Date for all records unless I specify a different expiration date or event here: _______________.

I understand that there may be a charge to cover actual costs incurred by In Balance Physical Therapy up to $15.00 in preparing and delivering the information requested in this authorization, in accordance with Maryland statutes and In Balance Physical Therapy policies.

Signed: _______________________ Date: __________ Printed name: _______________

Signed if legal representative: _______________________ Date: __________ Relationship to the patient: _______________
Printed name: _______________________________________

Witness: _______________________________________ Date: _______________

PAST MEDICAL HISTORY

REASON FOR YOUR VISIT TODAY: ______________________________

ALLERGIES (MEDICATION/FOOD, INDICATE REACTION): ☐ NONE ______________________________

MEDICATION LIST: (PLEASE LIST NAME/DOSE/FREQUENCY IF KNOWN) ______________________________

Habits: Alcohol: ☐ None ☐ Yes: How many drinks/day ______ frequency/week _______ What kind ________
Tobacco: ☐ None ☐ Yes: Chew or smoke? ________ How many/day ______ since ________________
Caffeine: ☐ None ☐ Yes: What kind ________________ How many/day ________________
Other Recreational Drugs: ☐ None ☐ Yes: What kind ____________ How many/day __________
Do you drive? ☐ Yes ☐ No
Do you exercise? ☐ Yes ☐ No
Sexual preference: ☐ Men ☐ Women ☐ Both
History of sexual abuse? ☐ Yes ☐ No
Are you sexually active? Y N
If No, would you like to be sexually active? ☐ Yes ☐ No

Children (age): ______________________________
Hobbies: ______________________________
Sports: ______________________________
Pets: ______________________________
Other: ______________________________

PAST SURGICAL HISTORY (INDICATE DATE IF KNOWN)

- ☐ None
- ☐ Cardiac Stents __________
- ☐ Heart Valve __________
- ☐ Appendectomy __________
- ☐ Hemorrhoidectomy __________
- ☐ Hysterectomy __________
- ☐ Spinal Surgery __________
- ☐ Bladder surgery __________
- ☐ C-Section __________
- ☐ Coronary Bypass __________
- ☐ Pacemaker __________
- ☐ Gall Bladder __________
- ☐ Bowel/Stomach Resection __________
- ☐ Bariatric surgery __________
- ☐ Hernia __________
- ☐ Tubal Ligation __________
- ☐ Prostate surgery/resection __________
- ☐ Orthopedic/joints __________

Other ______________________________

Past Medical History

Condition	Yes	No
Stroke	☐ Yes	☐ No
Diabetes (Type 1 or Type 2)	☐ Yes	☐ No
Hearing Loss	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Blood Clots	☐ Yes	☐ No
Pulm Emboli (lung clots)	☐ Yes	☐ No
Reflux	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Coronary Disease	☐ Yes	☐ No
MI/heart attacks	☐ Yes	☐ No
Congestive Heart Failure	☐ Yes	☐ No
Atrial Fibrillation	☐ Yes	☐ No
STD __________	☐ Yes	☐ No
Gastrointestinal Bleeding	☐ Yes	☐ No
Hepatitis (A, B, C)	☐ Yes	☐ No
HIV / AIDS	☐ Yes	☐ No
Chronic Wounds	☐ Yes	☐ No
Cancer (type) __________	☐ Yes	☐ No
Incontinence	☐ Yes	☐ No
Kidney Stones	☐ Yes	☐ No
COPD (Emphysema, Bronchitis)	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Bipolar Disorder	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No
Chronic Fatigue Syndrome	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No

Other ______________________________

If you are here for issues specifically related to *Women's Health* please also complete the following questions:

OB: Are you Pregnant? Y N If yes, when was your last Ob-gyn visit? ____________
Number of Pregnancies: ____ Vaginal Deliveries: ___ C-Sections: ___ DandC: ___ Miscarriages: ___ Abortions: ___
Longest Length of pushing: ______________ Number of episiotomies: __________ Number of tears: ________
Do you have a painful episiotomy scar? Y N Do you have a painful C-section scar? Y N

GYN: Do you experience menstrual pain? Y N Do you have endometriosis? Y N
Have you experienced menopause? Y N Approximate date of onset? __________
Have you been on hormone replacement therapy? Y N If yes, what type? ____________________________

UROLOGY: Do you have a history of frequent UTI? Y N Do you have a history of urine loss as a child? Y N
Do you have a history of urine loss as an adolescent? Y N Do you have a history of urine loss during pregnancy or after childbirth? Y N
Do you have Interstitial Cystitis? Y N Do you have IBS? Y N

If you are here for issues specifically related to *MENS HEALTH* please also complete the following questions:

Sexual Function:
Do you have any difficulty getting or keeping a firm (hard) erection? Y N
Do you have trouble maintaining a firm (hard) erection to completion of intercourse (i.e. Do you lose your erection too quickly)? Y N
Can you achieve an orgasm? Y N Can you ejaculate normally? Y N
Do you experience pain with erections? Y N Do you experience pain with orgasm? Y N

Prostate:
Have you ever been treated for prostate cancer? Y N Have you had surgery for prostate cancer? Y N
Have you had radiation for prostate cancer? Y N Have you had surgery for benign prostate enlargement? Y N
Are you on androgen deprivation therapy for prostate cancer? Y N

Urology:
Do you have a history of frequent UTI? Y N Do you have a history of urine loss as a child? Y N
Do you have a history of urine loss as an adolescent? Y N Do you have Interstitial Cystitis (Painful Bladder Syndrome)? Y N

HIPAA Notification

Notice of Privacy Practices : We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this notice, please contact the Privacy Officer at this practice. If you would like detailed information regarding how we may use and disclose medical information about you and your individual rights regarding your medical information, please let us know and you will be provided with a copy of our Privacy Practices.

Patient Statement : I am aware that this practice, as required by law, maintains the privacy of protected health information as prescribed by HIPAA and that I have access to its provisions. I have been provided an opportunity to review the Notice of Privacy Practices. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in the Notice. I may revoke this authorization at any time in writing.

Print Name: ______________________________________ Date of Birth: ____________________
Signature: _______________________________________ Date: _________________________

In Balance Physical Therapy: FINANCIAL POLICY

We are pleased that you have selected our office to address your women's health and orthopedic physical therapy needs. As part of that care, we have developed this statement of our financial policy. Please carefully read the following and then initial in the space provided near each paragraph, and then sign below.

1) ____Health Insurance Participation: In Balance Physical Therapy participates with many, but not all health insurance plans. If we do participate with your health insurance plan, you must present a valid insurance identification card at check-in. Without a valid insurance card, or if we do not participate in your health insurance plan, you will need to speak with the office manager or owner prior to treatment.
2) ____Co-Payments/Co-insurance: Some insurance plans require payment of a Co-pay or Co-insurance. Payments are due at check-in or check-out. Payments may be made by check, cash, MasterCard or VISA.
3) ____Referrals: Some insurance plans require a written referral from a primary care provider. Referrals must be presented at check-in. Having a valid referral is a patient's responsibility. It is your responsibility to know how many visits are allowed on your referral and the expiration date of your referral. Without a valid referral if you need one for your insurance, you may reschedule your appointment or payment for your visit will be due upon treatment.
4) ____Financial Responsibility: Patients are responsible for all co-payments, deductibles, and charges not covered by health insurance.
5) ____Deductibles: If you have a large deductible ($500/contract year or more) that has not yet been met, you will pay $75.00 per visit up front until you receive your Explanation of Benefits (EOB) from your insurance company. Once your EOB has been sent and the exact amount due is learned, you will be responsible for the remainder of your deductible (if any) at that time. If you have overpaid on your deductible, you will be reimbursed within 7 to 14 days of IBPT receiving your EOB from your insurance company.
6) ____Account Balances: All outstanding balances must be paid at time of check-in, or if you need, you may set up a payment plan with the office manager or owner. Failure to pay outstanding balances in a timely manner may result in the practice forwarding your account to a Collection Agency or Collection Attorney of our choice and may result in additional fees, including an administrative fee of 30%. Again, you may set up a payment plan with the owner, and this will be set up on an individual basis. You will be given plenty of fair notice prior to any balance being sent to a Collection Agency. Any unpaid balances will be subject to a $15 per month late charge for each month left unpaid.
7) ____Cancellation: Any cancellation made over the weekend or on a holiday for the very next business day will be subject to a $50.00 cancellation fee.
8) ____Cancellation/No-Show: You must cancel any appointment with a full 24 hour business days notice on the telephone or via email (jberger@inbalancephysicaltherapy.com) or you are subject to a $50.00 cancellation/No-Show fee.

I (the client of In Balance Physical Therapy) have read and understand the office policies explained above:

Signature:______________________________ Date:________________

Print Name:_____________________________

OFFICE USE ONLY - Do not sign:

Therapist who reviewed financial policy with this client:

(Print Name):____________________ Signature:______________________ Date:___________