SEARCY PHYSICAL THERAPY

PATIENT INFORMATION			EMAIL ADDRESS:
First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -		Spouse:
Chose Clinic Because/ Referred to Clinic By ☐ Dr.:		☐ Insurance Plan ☐ Family ☐ Friend	
☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:			

WORK INFORMATION		
Employer:	Work Phone ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION	
Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)	
Primary Insurance Name:	
Subscriber's Name (If different):	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	
Name of Secondary Insurance:	
Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	

AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)			
Insurance Name: ☐ Auto :	☐ Labor & Industries:		
Adjuster/Claim Manager:		Phone:	Ext.:
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

ATTORNEY INFORMATION			
Name:	Law Firm:	Phone: ( ) -	
Address	City	State:	Zip:

IN CASE OF EMERGENCY		
Name of Local Friend or Relative (Not Living at Same Address):		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to Searcy Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Searcy Physical Therapy to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

SEARCY PHYSICAL THERAPY

PATIENT QUESTIONNAIRE: PRENATAL & POSTPARTUM

Name: _____ **Age:** _____ **DOB:** _____

Referring Doctor: _____ **Diagnosis:** _____

Have you received previous Physical Therapy for this problem? (circle) No OR Yes: (date):_____

Have you received other treatment for this problem? No OR Yes: (type)_____

Medical History (circle all that apply): heart problems / hypertension / diabetes / cancer / seizures thyroid dysfunction / hx of fractures / asthma / chronic bronchitis / lung disease / smoker / osteoarthritis rheumatoid arthritis / hx of stroke / kidney problems / depression / preeclampsia / osteoporosis / DVTs

Other:_____

Surgical History (list type & date): _____

_____

Gynecological History (fill in blanks or circle answer for all that apply): Number miscarriages_____

Number of pregnancies_____. Number of vaginal deliveries_____. Number of C-sections_____

Number of episiotomies_____. Number of vacuum/forceps assisted deliveries _____.

Birthdates & weight of each baby: _____

Any physical problems after previous deliveries? _____

_____

Any active infections at this time? No OR Yes: (specify type/treatment)_____

(Circle any that apply): Feelings of pelvic heaviness / history of: fibroids / cysts / endometriosis

Current Medications: _____

Allergies: _____

Work Status: ☐ currently working ☐ on maternity leave ☐ not employed ☐ other:_____

Location / type of work: _____

Emergency Contact:

Name: _____ Daytime phone #: (____)_____-_____

How did you learn about us? ☐ friend ☐ physician ☐ internet ☐ advertisement ☐ other:

Date of your next doctor's appointment: _____

_____ _____

Patient's Signature **Date**

PERINATAL: SYMPTOM QUESTIONNAIRE

Current Status: (Check by statement that applies and answer subsequent questions.)

___ **I am currently pregnant.**

I am at _____ weeks gestation, with the due date of _____ .

Have you had any concerns during this pregnancy? No OR Yes (please specify below)

_____

Has your physician placed you on any restrictions? No OR Yes (please specify below)

_____

Have you experienced any problems during previous pregnancies? No OR Yes (specify)

_____

___ **I am post-partum.**

I am ____ weeks post-partum, having delivered on the date of _____.

Type of delivery (circle all that apply): vaginal / forceps / vacuum / episiotomy / perineal tear/ C-section . If C-section, was it planned or did you labor prior to the procedure?_____

If perineal tear, do you know what grade tear? _____

Did you experience any problems during this pregnancy? No OR Yes (please specify):

_____

Are you experiencing problems at the site of C-section, episiotomy or perineal tear? No OR Yes (specify): _____

___ **I recently experienced a miscarriage.**

Date of miscarriage: _____

Any other information: _____

Bowel / Bladder Symptoms: (Answer "yes" or "no." If "yes," describe the problem.)

Are you experiencing any problems with urinating or leaking urine? _____

_____

Are you experiencing any problems with bowel movements or leaking feces? _____

_____

Current Symptoms:

What brings you in for therapy today? _____

Do you have pain? No OR Yes: location:_____

Describe how the pain feels: _____

When did pain first begin: _____

Are any of your normal activities limited by pain? No OR Yes: (specify)_____

_____

What makes your pain worse?:_____

Better?: _____

Rate your pain on the following scale: 0=no pain at all, 5=moderate pain, 10=worst pain imaginable

At worst (circle one): 0 1 2 3 4 5 6 7 8 9 10 On average: 0 1 2 3 4 5 6 7 8 9 10

Is there any other information you would like to share about your symptoms? _____

_____

_____

What do you hope to achieve through therapy: _____

_____

_____

SEARCY PHYSICAL THERAPY

PELVIC FLOOR CONSENT FOR EVLAUATION 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 initial 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 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 present in the room during the procedure and _____choose or _____refuse this option.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name of Patient or Personal Representative Date

_____ _____

Witness Signature Date

— SEARCY —
PHYSICAL
THERAPY

ADDENDUM: PATIENT PRIVACY

Patient's Name:_____

Date of Birth:_____

Social Security Number:_____

In an effort to comply with current **HIPAA** (Health Insurance Portability Accountability Act) regulations, we need you to complete the following information. Please list any person other than your doctor with whom we may discuss your private health information or financial matters:

Name:_____Phone:_____Relationship:_____

Name:_____Phone:_____Relationship:_____

Name:_____Phone:_____Relationship:_____

In the event that we are unable to reach you personally, do you give your permission to a staff member of Searcy/Des Arc Physical Therapy to leave a message on your answering machine, voicemail, and/or with someone at your home/cell number concerning your private health information or financial matters? (Check yes or no)

YES_____ NO_____

I understand that I can withdraw the above at any time, with written request. I also understand that it is my responsibility to ensure that my family member or significant other do not divulge or use the information in any way without discussing with me first.

Automated Reminders: Consistency is a vital component to successful therapy. As a courtesy to patients, Searcy Physical Therapy will routinely send automated text messages or emails reminding patients of upcoming appointments. Please choose one of the following preferences for text or email reminders:

- ☐ I prefer to receive reminders via text message at the following number: _____
- ☐ I prefer to receive reminders via email at the following address: _____
- ☐ I prefer not to receive reminders via text or email.

_____ _____

Signature of Patient or Legally Authorized Individual Date

_____

Relationship to patient if signed by anyone other than the patient
(Such as: Parent, Legal Guardian, Personal Representative, etc.)

Acknowledgement of Patient's Financial Responsibility

I understand that Searcy Physical Therapy will call to confirm insurance benefits before my first appointment as a courtesy. I understand that it is highly recommended that I also call to confirm benefits as policy holders sometimes have access to privileged information that providers do not.

I understand that verification of insurance benefits does not guarantee payment.

I understand that I will be financially responsible for any charges not covered by my insurance company. Many insurance policies require some patient responsibility in the form of a copay, deductible, coinsurance or some combination thereof.

I understand copays are due at the time of each appointment. I understand that I will be billed for any portion of charges my insurance assigns as patient responsibility as claims are processed.

I authorize the release of any medical information necessary to process insurance claims for services and / or supplies provided by Searcy Physical Therapy / Des Arc Physical Therapy.

I authorize payment of medical benefits to Andrew Abraham, PT, PA /dba, Searcy Physical Therapy / Des Arc Physical Therapy.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient

SEARCY PHYSICAL THERAPY

APPOINTMENTS, CANCELLATIONS AND NO SHOW POLICY

PLEASE READ CAREFULLY

The therapists and staff of Searcy Physical Therapy are glad you are here. *You* are the reason this physical therapy practice exists, and we promise to never forget that! Your successful rehabilitation is our top priority. To achieve the best possible outcome we and/or your doctor have recommended a particular treatment schedule. To attain these results, it is very important that you attend your therapy sessions as scheduled.

No Shows: If you are unable to keep a scheduled appointment, please let us know **2 hours in advance**. A **NO SHOW** is when a patient fails to keep a scheduled appointment or does not notify our office at least 2 hours in advance. Please note that our office must be notified directly. Texting or calling your therapist on their personal cell is not considered notifying us as they can't always notify the office staff if they're treating other patients.

We ask patients to try to never no show for an appointment. We promise to value your time and ask for the same courtesy. If a patient no shows for more than one appointment, they can then only schedule same day appointments. The patient will need to call on a day they'd like to come and see if there are any openings available that day. If the patient then continues to no show or cancel appointments with less than 2 hours notice, we will no longer be able to treat them at Searcy Physical Therapy.

Chronic Cancellations: It is common practice for us to schedule patients' appointments for several weeks out as a courtesy and convenience for patients who know they want to come at the same time every week. However, we will not be able to provide this service to patients who chronically cancel or reschedule appointments. For this purpose, we define "chronic" as routinely cancelling or rescheduling one appointment, or more, per calendar week. If a patient cancels or reschedules with this frequency, we will need to cancel all their future scheduled appointments and begin scheduling only a maximum of two appointments at a time (each time the patient comes for an appointment, we'll schedule their next one to two appointments).

Workers' Compensation and Personal Injury: Worker's Compensation and Personal Injury patients' documents of any missed or cancelled appointments are forwarded to your case manager and primary care doctor. This could jeopardize your claim and prolong or stop any benefits that you may be entitled to.

Emergencies: We understand that sometimes emergencies happen. Please always give our office as much notification as possible about any appointment you will miss when an emergency happens. Searcy Physical Therapy may waive the above policy at their discretion when they deem a situation as emergent.

We appreciate the opportunity to provide you with uncompromising care. Thank you for your consideration of our staff and other patients.

Signing below indicates you understand and agree to the terms of this policy.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name of Patient or Personal Representative Date