FOUNDATION PHYSICAL THERAPY

PATIENT'S NAME _____ **DATE** _____ **DATE OF BIRTH** _____

HEIGHT: _____ **WEIGHT:** _____ **lbs. (Insurance required) MARITAL STATUS: ( ) married ( ) single ( ) widowed ( ) divorced**

WORK STATUS (full, part, retired) _____ **OCCUPATION:** _____

CURRENT MEDICATIONS: (Required) _____

EMERGENCY CONTACT: _____ **PHONE ( )**_____

WHO IS YOUR PRIMARY CARE PHYSICAN? _____ PHONE ( )_____

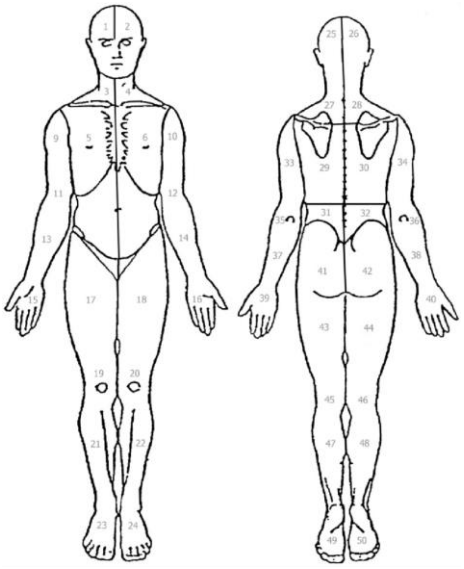
MEDICAL AND SURGICAL HISTORY: Check all that apply

MEDICAL/SURGICAL HISTORY

□ **Diabetes**
□ **Falls in the past year: □ No □Yes**
How many_____ Injury? _____
□ **Cancer where?** _____
when? _____
□**Pacemaker**
□ **Osteoporosis**
□ Circulation problems
□ Heart problems
□ High blood pressure
□ Broken bones/fracture
□ Lung problems
□ Stroke
□ Hypoglycemia/low blood sugar
□ Head injury
□ MS
□ Parkinson's disease
□ Seizures/epilepsy
□Thyroid problems
□ Infectious disease
□ Kidney problems
□ Skin diseases
□ Depression
□ Allergies: _____
□ Other: _____
□ Other: _____
□ Other: _____

Have you had any of the following symptoms? (Check all that apply)

□ Chest pain
□ Heart palpitations
□ Shortness of Breath
□ Dizziness or blackouts
□ Coordination problems
□ Weakness of the arms or legs
□ Loss of balance
□ Difficulty walking
□ Joint pain or swelling
□ Pain at night
□ Difficulty sleeping
□ Loss of appetite
□ Nausea/vomiting
□ Difficulty swallowing
□ Weight loss/gain
□ Urinary problems
□ Fever/chills/ sweats
□ Headaches
□ Hearing problems
□ Arthritis
□ Vision problems
□ **Any surgeries:**
_____
_____
_____
_____
_____



KEY

XX Pain
OO Tingling
ZZ Numbness

CURRENT CONDITION

-What is your current complaint for which you seek physical therapy?
_____

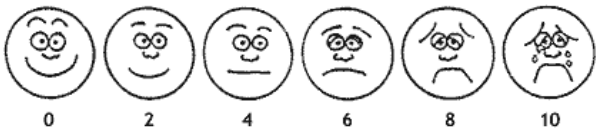
When did the problem begin? _____

-What happened? _____

-Have you ever had the problem(s) before?
□ **Yes**
What did you do for the problem_____
Did the problem get better? _____
How long did the problem last?_____
□ **No**

What are your goals for Physical Therapy? _____

Wong-Baker FACES Pain Rating Scale



From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P.: Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.

Current pain level: /10
Best pain level in month: /10
Worse pain level in month: /10

2020

FOUNDATION PHYSICAL THERAPY
NOTICE of PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office with a written request. By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996.

The patient understands that:

-Protected health information may be disclosed or used for treatment, payment or health care operations
-The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
-The Practice reserves the right to change the Notice of Privacy Policies.
-The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
-The Practice may condition treatment upon the execution of this consent.

Please list the family members or other persons, if any, whom we may inform about your general medical condition/diagnosis:

Name: _____ Phone: _____

_____ _____
Date PRINT Patient's/Insured's Name

_____ _____
Practice Representative (WITNESS) SIGNATURE of Patient/Insured (Parent Signature if Child)

FOUNDATION PHYSICAL THERAPY **INSURANCE AUTHORIZATION**

I hereby assign all medical/physical therapy benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Foundation Physical Therapy. This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am ultimately responsible for all charges, whether or not paid by said insurance. I also understand that, should I default on my account, all costs of attorney's fees, interest (18% annum or 1.5%per month) and cost of collections would be my responsibility. I hereby authorize said assignee to release all information necessary to secure payment and to complete disability forms on my behalf if necessary. In the case of returned checks, the fee charged by the bank will be added to your account. PATIENTS ARE RESPONSIBLE FOR NOTIFICATION OF ANY CHANGES WITH INSURANCE PLANS OR COVERAGE.

_____ _____
Date PRINT Patient's/Insured's Name

_____ _____
Practice Representative (WITNESS) SIGNATURE of Patient/Insured (Parent Signature if Child)

FOUNDATION PHYSICAL THERAPY **PATIENT INFORMED CONSENT**

I hereby indicate my wish to be a participant in the rehabilitation program by Foundation Physical Therapy. I understand that the purpose of this program is to enhance my recovery from an injury, illness or problem. I further understand that there exists the possibility that certain changes may occur during treatment. I understand that I will be informed of the procedures and methods of treatment that will be administered to me, and understand what is required of me as a patient. I verify that my participation is fully voluntary, and no coercion of any sort has been used to obtain my participation, and I may withdraw from treatment at any time. I understand that the facility administrator, Gary Parsonis 727-784-6088 maintains an open door policy and encourages calls Monday – Friday 8:00-5:00 to discuss rehabilitation issues. We understand that cancellations are sometimes unavoidable, but cancellations must be 24 hours in advance or rescheduled in the same week to avoid a cancellation fee of $60.00. No show appointments will be assessed a $60.00 no show fee. If you cancel 3 or more time, we have the right to discharge you from services. **COPAYS ARE DUE AT TIME SERVICES ARE RENDERED.** THERE WILL BE A $15.00 ADDITIONAL CHARGE FOR EVERY COPAY NOT RECEIVED ON THE DAY OF SERVICE.

_____ _____
Date PRINT Patient's/Insured's Name

_____ _____
Practice Representative (WITNESS) SIGNATURE of Patient/Insured (Parent Signature if Child)

FOUNDATION PHYSICAL THERAPY **FOR MEDICARE/MEDICARE REPACEMENT S RECEIPIENTS:**

I have been informed by Foundation Physical Therapy, that Medicare will not pay for Physical Therapy benefits if I am enrolled in Home Health Care, Hospice or receiving treatment at a skilled nursing facility. My signature below acknowledges that I am not receiving any of these services. I will be financially responsible for any financial liability from Foundation Physical Therapy if I were receiving these services while attending PT at Foundation Physical Therapy.

_____ _____
Date PRINT Patient's/Insured's Name

_____ _____
Practice Representative (WITNESS) SIGNATURE of Patient/Insured

To Our Patients Regarding Cancellations and No-Shows

We take cancellations and no-shows seriously at Foundation Physical Therapy.

We know that your appointments and treatments can make a difference in whether or not you are successful in your goals. Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- **We *require* 24 hours notice** in the event that you need to cancel your appointment. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.

- **There is a $60.00 charge for a cancellation without proper notice or if you are a No-Show.** This charge will *not* be covered by insurance and will have to be paid by you personally.

- For Worker's Compensation and Personal Injury patients, documentation of any missed appointments is forwarded to your Case Manager and Primary Physician. This could jeopardize your claim.

- You might need to see a therapist other than the one who normally treats you if you do change your appointment. All of our therapists are experienced doctors of physical therapy. They will review your patient chart, and the quality of care will be consistent.

- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is improved or resolved. Either condition can seem to be a reason not to come in: a) You're feeling worse and think the treatment is not working or, b) You're feeling better and it's a great day for yard work. Neither of these conditions is legitimate as a reason not to come. If you're in pain, come in and get it fixed. If you're out of pain, now is the time that we begin doing some real correction of the underlying causes of your problem, educate you so you won't re-injure yourself, or speak to your therapist to discuss a discharge from services etc.

When you don't show as scheduled, three people are hurt: You, because you don't get the treatment you need as prescribed by the doctor and/or Physical Therapist; the therapist, who now has a space in their schedule since the time was reserved for you personally; and another patient, who could have been scheduled for treatment if you had given proper notice.

We appreciate your cooperation and understanding. We look forward to working with you.

_____ _____ _____

Patient Signature **Date** Office Staff Signature

Insurance Protocol

MEDICARE: Physical Therapy, Inc. is a Medicare Participating Foundation Provider. If you are a Medicare recipient your claim will be electronically filed. Upon receipt of payment/and or denial from Medicare, your secondary insurance will be billed as a courtesy, one time only. If there is a remaining balance after both insurance companies have been billed you will be responsible for this balance which will be provided for you in the form of a statement. Please note that we do not verify secondary insurances. Please contact your secondary insurance at the customer service number on the back of your card to verify your coverage and to see if any deductibles or co-payments apply to physical therapy charges.

COMMERCIAL INSURANCE/GROUPINSURANCE: (Insurance through your work or private insurance) Before your initial evaluation our office staff will verify your benefits. We will explain how much your insurance informed us they will cover and if there will be a co-payment, or deductible due, but is it your responsibility to understand and contact your insurance provider for details. You will be expected to pay your co-pay at the start of each visit. Please ask for a receipt upon payment if needed.

Foundation Physical Therapy, Inc.

Difficulty–Baseline

Name: _____ **Date:** _____

Instructions: Please circle the level of difficulty you have for each activity today.	**Able to do without any difficulty**	**Able to do with little difficulty**	**Able to do with moderate difficulty**	**Able to do with much difficulty**	**Unable to do**	**Not applicable**
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking–short distance	1	2	3	4	5	9
10. Walking–long distance	1	2	3	4	5	9
11. Walking–outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

Please rate your pain level in the last 2 weeks. Fill in the blanks.

(0= no pain, 10=severe pain)

Currently: /10,

Best /10,

Worse /10

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FOUNDATION PHYSICAL THERAPY
29605 US 19 N. STE 360
CLEARWATER, FL 33761
727-784-6088
FAX: 727-784-3034

TELEMEDICINE INFORMED CONSENT FORM

Patient Name: _____ **DOB:** _____

You are going to have a clinical encounter using videoconferencing technology. You will be able to see and hear the provider and they will be able to see and hear you, just as if you were in the same room. The information may be used for diagnosis, treatment, therapy, follow-up and/or education.

Expected Benefits:

- Improved access to care by enabling a patient to remain within the facility and obtain services from providers at distant sites.
- Patient remains closer to home where local healthcare providers can maintain continuity of care.
- Reduced need to travel for the patient or other provider

The Process:

You will be introduced to the provider and anyone else who is in the room with the provider. If you are unsure of what is happening, you may ask questions of the provider, anyone with the provider, or any telemedicine staff in the room with you. If you are not comfortable with seeing a provider on videoconference technology, you may reject the use of the technology and schedule a traditional face to face encounter at any time. Safety measures are being used to ensure that this videoconference is secure, and no part of the encounter will be recorded without your written consent.

Possible Risks:

There are potential risks associated with the use of telemedicine which include, but are not limited to:

- A provider may determine that the telemedicine encounter is not yielding sufficient information to make an appropriate clinical decision, which may require additional in-person visits.
- Technology problems may delay medical evaluation and treatment for today's encounter.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. You will be promptly notified if any security issues arise.

By signing this form, I understand the following:

1. I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
2. I understand that if the provider believes I would be better served by a traditional face-to-face encounter, the provider may, at any time stop the telehealth visit and schedule a face-to-face visit. Therefore, I understand the technology problems may necessitate an in-person visit with the provider.
3. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
4. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine.
5. I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

Patient Consent to the Use of Telemedicine:

I have read and understand the information provided above regarding telemedicine, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my care. I also consent to photographs of this video encounter being taken and stored in my patient file.

I hereby authorize Foundation Physical Therapy to use telemedicine in the course of my diagnosis and treatment.

Signature of patient(or authorized person) _____Date_____

If authorized signer, relationship to patient _____

Witness _____Date_____

PHQ-9

Name: _____ **Date:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING *0* **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
⑤	⑤	⑤	⑤

Patient Name: _____

Date: _____

UROGENITAL DISTRESS INVENTORY SHORT FORM (UDI-6)

Please answer each question by checking the best response. While answering these questions, please consider your symptoms over the last 3 months. We realize that you may not be having problems in some of these areas, but please fill out this form as completely as possible.

Do you experience, and if so, how much are you bothered by...	Not at all	Slightly	Moderately	Greatly
Frequent urination	0	1	2	3
Leakage related to feeling of urgency	0	1	2	3
Leakage related to physical activity, coughing, or sneezing	0	1	2	3
Small amounts of leakage (drops)	0	1	2	3
Difficulty emptying bladder	0	1	2	3
Pain or discomfort in lower abdominal or genital area	0	1	2	3

INCONTINENCE IMPACT QUESTIONNAIRE-SHORT FORM (IIQ-7)

Some people find that accidental urine loss may affect their activities, relationships, and feelings. The questions below refer to areas in life that may have been influenced or changed by your problem. For each question, circle the response that best describes how much y activities, relationships, and feelings are being affected by urine leakage.

Has urine leakage affected your...	Not at all	Slightly	Moderately	Greatly
1. Ability to do household chores (cooking, housecleaning, laundry)?	0	1	2	3
2. Physical recreation such as walking, swimming, or other exercise?	0	1	2	3
3. Entertainment activities (movies, concerts, etc.)?	0	1	2	3
4. Ability to travel by car or bus more than 30 minutes from home?	0	1	2	3
5. Participation in social activities outside your home?	0	1	2	3
6. Emotional health (nervousness, depression, etc.)?	0	1	2	3
7. Feeling frustrated?	0	1	2	3

Items 1 and 2 = physical activity; Items 3 and 4 = travel
Item 5 = social/relationships; Items 6 and 7 = emotional health

Scoring: Item responses are assigned values of 0 for "not at all," 1 for "slightly," 2 for "moderately," and 3 for "greatly." The average score of items responded to is calculated. The average, which ranges from 0 to 3, is multiplied by 33 1/3 to put scores on a scale of 0 to 100.

Reference: Uebersax, J.S., Wyman, J.F., Shumaker, S.A., McClish, D.K., Fantl, J.A., & the Continence Program for Women Research Grou (1995). Short forms to assess life quality and symptom distress for urinary incontinence in women: the Incontinence Impact Questionnai and the Urogenital Distress Inventory. *Neurology and Urodynamics, 14*(2), 131-139.

TEST SCORE	PERCENTAGE	MODIFIER
0	0% IMPAIRED	CH
1-4	1-19% IMPAIRED	CI
5-9	20-39% IMPAIRED	CJ
10-14	40-59% IMPAIRED	CK
15-19	60-79% IMPAIRED	CL
20-23	80-99% IMPAIRED	CM
24		

Please complete if you have urinary or fecal incontinence.....

1. How many times do you go to the bathroom during waking hours to urinate in a day? _____ to have a bowel movement? _____

2. Of those times to the bathroom, how many are with urgency? _____

3. How many times do you wake to go to the bathroom at night? _____

4. Do you wear protection from incontinence? panti-liner, maxi pad, full undergarment/ depends *(circle)*

How often do you change it in 24 hours? _____

5. Have you heard about pelvic floor strengthening/ Kegels? _____
If so from who?
_____
How many weeks did you try strengthening at home *(Medicare requires 4 weeks of home exercises to cover outpatient PT)* ?
_____
Did you stop home exercises? _____

Why? _____

Pelvic Floor Distress Inventory (PFDI-20)

Patient Name:_____
Date: _____ **DOB**_____

Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6)	**NO**	**YES**			
		If yes, how much does it bother you?			
	No	**Not at all**	**Somewhat**	**Moderately**	**Greatly**
Do you usually experience *pressure* in the lower abdomen?	0	1	2	3	4
Do you usually experience *heaviness* or *dullness* in pelvic area?	0	1	2	3	4
Do you usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1	2	3	4
Do you ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1	2	3	4
Do you usually experience a feeling of incomplete bladder emptying?	0	1	2	3	4
Do you 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 (CRADI-8)	**No**	**Not at all**	**Somewhat**	**Moderately**	**Greatly**
Do you feel you need to strain too hard to have a bowel movement?	0	1	2	3	4
Do you feel you have not completely emptied your bowels at the end of a bowel movement?	0	1	2	3	4
Do you usually lose stool beyond your control if your stool is well formed?	0	1	2	3	4
Do you usually lose stool beyond your control if your stool is loose?	0	1	2	3	4
Do you usually lose gas from the rectum beyond your control?	0	1	2	3	4
Do you usually have pain when your pass your stool?	0	1	2	3	4
Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1	2	3	4
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)	**No**	**Not at all**	**Somewhat**	**Moderately**	**Greatly**
Do you usually experience frequent urination?	0	1	2	3	4
Do you usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of need to go to the bathroom?	0	1	2	3	4
Do you usually experience urine leakage related to coughing, sneezing, or laughing?	0	1	2	3	4
Do you usually experience small amounts of urine leakage (that is, drops)?	0	1	2	3	4
Do you usually experience difficulty emptying your bladder?	0	1	2	3	4
Do you usually experience *pain* or *discomfort* in the lower abdomen or genital region?	0	1	2	3	4

Test Score	Percentage	Modifer
0	0 %	CH
0-15	1-19 %	CI
16-31	20-39 %	CJ
32-47	40-59 %	CK
48-63	60-79 %	CL
64-79	80-99 %	CM
80	100 %	CN

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 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 _____ refuse this option.

Date: _____ Patient Name: _____

_____ _____

Patient Signature Signature of Parent or Guardian (if applicable)

_____

Witness Signature