WOMEN'S ADVANTAGE
MEN'S OPTIMAL HEALTH
specialized pelvic physical therapy

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI:___ Date of Birth: _____/_____/_____

Parent or Guardian Name: _____ Relationship to Patient: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Home Email: _____ Work Email: _____

Please check if you would like to receive: ☐ E-mail Appointment Reminders ☐ E-Newsletter

Referring Physician: _____ Physician's Phone: (_____) _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner: *(Check all that apply.)*

By phone at: ☐ Home ☐ Work ☐ Cell ☐ Other: (____) _____

☐ Ok to leave message with detailed information at: ☐ Home ☐ Work ☐ Cell ☐ Other

☐ Leave message with call back number only at: ☐ Home ☐ Work ☐ Cell ☐ Other

In writing to: ☐ Home Fax: (____) _____ ☐ Work Fax: (____) _____
☐ E-mail Address
☐ Home Address ☐ Work/Office Address ☐ Different address: _____

_____ _____
Patient Name (Please Print) Patient Signature

_____ _____
Signature of Parent or Guardian (If applicable) Date

20911 Earl Street, Suite 300 ◆ Torrance, CA 90503
(310) 370-1200 Phone ◆ (310) 370-1233 Fax ◆ www.womens-advantage.com

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PEDIATRIC CONSENT FOR EVALUATION AND TREATMENT

Informed consent for treatment:

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

I also acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor or bladder functions, or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform a pelvic floor muscle examination. This examination is performed primarily by observing and/or palpating the external perineal region. No internal examination is done. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, and function of the pelvic floor region.

Treatment may include, but not be limited to the following: observation, palpation, biofeedback and/or electrical stimulation, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

Potential risks: I may experience an increase in my current level of pain or discomfort if any, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 day, I agree to contact my physical therapist.

Potential benefit: I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical, or pharmacological alternatives with my physician or primary care provider.

Release of medical records: I authorize the release of my medical records to my physician/primary care provider or insurance company.

Cooperation with treatment: 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 physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

No warranty: I understand that the therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of treatment for my condition and will discuss all treatment options with me before I consent to treatment.

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 Women's Advantage Men's Optimal Health Physical Therapy.

_____	_____
Patient Name (Please Print)	Patient Signature
_____	_____
Signature of Parent or Guardian (If applicable)	Date

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FINANCIAL POLICY

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. Should your insurance company request a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same to Women's Advantage Inc. You also agree to assign all medical and/or surgical benefits to which you are entitled, including Medicare, Medicaid, private insurance and third party payors to Women's Advantage Inc.

Estimated coverage information is provided as a courtesy to you. **Please realize this is only a good faith payment toward your final bill. This is not payment in full.** If you have a deductible and/or co-insurance, we will collect towards the patient portion responsibility which is an approximate amount. You may be billed for an additional amount once your claim has been processed. There will be a $20.00 service fee for all returned checks. If you fail to make any of the payment for which you are responsible in a timely manner, you will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

CANCELLATION POLICY

Your cooperation with the following policies will enable our therapists to care for as many patients as their schedule allows and will assist you in getting the full benefit from your physical therapy.

- We require 24 hour cancellation notice.
- Due to a high volume of patients scheduled on a daily basis, patients are expected to be on time for their appointments. When patients are late, it greatly impacts the care of other patients. Patients will be allowed a **15-minute grace period**; otherwise late patients will be rescheduled.
- You will be charged $42.00 for a cancellation without at least 24 hours notice.
- You will be charged $52.00 for not showing up for your appointment with failure to give any notice.
- These charges are not covered by your insurance. **The fees will be applied to your credit card on the same day of cancelled and no showed appointments.**

EXTERNAL / INTERNAL SENSOR POLICY

In the evaluation and treatment of the majority of our patients, we use modalities such as biofeedback and/or electrical stimulation which require either external or internal sensors for the pelvic floor muscles. During your evaluation, your therapist will determine if your treatment will require the use of sensors. These sensors are not covered by insurance and need to be paid for by the patient upon receipt. The external sensor fee is $14.00 and the internal sensor fees range from $30.00 to $55.50. These charges are one time flat fees.

I have read and agree to comply with all of the policies outlined above. I understand my responsibility for the payment of my account.

_____ _____

Patient OR Patient Guardian's Signature Date

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NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

WOMEN'S ADVANTAGE INC. LEGAL DUTY

WOMEN'S ADVANTAGE INC. uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, WOMEN'S ADVANTAGE INC. may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

WOMEN'S ADVANTAGE INC. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We also provide information when required by law.

In any other situation, WOMEN'S ADVANTAGE INC. policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop further disclosures at any time.

WOMEN'S ADVANTAGE INC. may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. WOMEN'S ADVANTAGE INC. will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that WOMEN'S ADVANTAGE INC. may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. For further information on WOMEN'S ADVANTAGE INC. health information practices, or if you have a complaint, please contact the following:

WOMEN'S ADVANTAGE INC.
20911 Earl Street, Suite 300
Torrance, CA 90503

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PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand WOMEN'S ADVANTAGE INC. Notice of Patient Information Practices. I understand that WOMEN'S ADVANTAGE INC. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that WOMEN'S ADVANTAGE INC. will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in WOMEN'S ADVANTAGE INC. Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____ _____
Patient OR Patient Guardian's Signature Date

(*OPTIONAL*)
I also authorize WOMEN'S ADVANTAGE INC. to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

_____
Patient Name

_____ _____
Patient OR Patient Guardian's Signature Date

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PEDIATRIC HEALTH HISTORY AND SCREENING QUESTIONNAIRE

Patient History and Symptoms

Your answers to the following questions will help us to manage your child's care better.

Name of parent or guardian completing this form: _____

Child's name: _____ Date of Birth: _____ / _____ / _____

Height: _____ Weight: _____ lbs Grade: _____

Describe the reason for your child's appointment: _____

When did the problem begin? _____

Problem is (circle one): getting better getting worse staying the same

Referring physician: _____

Medications	Start Date	Reason for Taking
_____	____ / ____ / _____	_____
_____	____ / ____ / _____	_____
_____	____ / ____ / _____	_____
_____	____ / ____ / _____	_____

Has your child stopped or been unable to do certain activities because of their condition? For example, embarrassed to play with friends, can't go on sleepovers, feels ashamed about leakage, and avoids play dates. _____

_____

Does your child now have or had a history of the following?

___ Pelvic Pain
___ Low back pain
___ Diabetes
___ Latex sensitivity/allergy
___ Allergies
___ Asthma
___ Surgeries
___ Blood in urine
___ Kidney infections
___ Bladder infections
___ Vesicoureteral reflux Grade _____
___ Neurologic (brain, nerve) problems
___ Physical or sexual abuse
___ Other _____

If yes to any above, please explain and include dates: _____

_____

Does your child need to be catheterized? YES / NO

If yes, how often? _____

Bladder Habits

1. How often does your child urinate during the day?	_____ times per day, every _____ hours
2. How often does your child wake up to urinate after going to bed?	_____ times
3. Does your child awaken wet in the morning?	YES / NO If yes, _____ days per week
4. Does your child have the sensation (urge feeling) that they need to go to the toilet?	YES / NO
5. How long does your child delay going to the toilet once he/she needs to urinate (circle one)?	Not at all 11 – 30 minutes 1 – 2 minutes 31 – 60 minutes 3 – 10 minutes _____ Hours
6. Does your child take time to go to the toilet and empty their bladder?	YES / NO
7. Does your child have difficulty initiating the urine stream?	YES / NO
8. Does your child strain to pass urine?	YES / NO
9. Does your child have a slow, stop/start, or hesitant urinary stream?	YES / NO
10. Is the volume of urine passed usually… (circle one)	Large Average Small Very Small
11. Does your child have the feeling their bladder is still full after urinating?	YES / NO
12. Does your child have any dribbling after urination; i.e. once they stand up from the toilet?	YES / NO
13. Fluid intake (one glass = 8 oz = one cup)	___ of glasses per day (all types of fluid) ___ of caffeinated glasses per day
14. Does your child have "triggers" that make him/her feel like he/she can't wait to go to the toilet? (i.e. running water, etc.)	YES / NO Please list: _____

Bowel Habits

15. Frequency of movements	____ per day ____ per week Consistency: loose normal hard
16. Does your child currently strain to go?	YES / NO
17. Does your child ignore the urge to defecate?	YES / NO
18. Does your child have fecal staining on his/her underwear?	YES / NO How often? _____
19. Does your child have a history of constipation?	YES / NO How long has it been a problem? ____

SYMPTOM QUESTIONNAIRE

1. Bladder leakage (check all that apply)
   - ___ Never
   - ___ When playing
   - ___ While watching TV or video games
   - ___ With strong cough/sneeze/physical exercise
   - ___ With a strong urge to go
   - ___ Nighttime sleep wetting
2. Frequency of urinary leakage (# of episodes)
   - ___ # per month
   - ___ # per week
   - ___ # per day
   - ___ constant leakage
3. Severity of leakage (check one)
   - ___ No leakage
   - ___ Few drops
   - ___ Wets underwear
   - ___ Wets outer clothing
4. Bowel leakage (check all that apply)
   - ___ Never
   - ___ When playing
   - ___ While watching TV or video games
   - ___ With strong cough/sneeze/physical exercise
   - ___ With a strong urge to go
   - ___ Nighttime sleep wetting
5. Frequency of bowel leakage (# of episodes)
   - ___ # per month
   - ___ # per week
   - ___ # per day
6. Severity of leakage (check one)
   - ___ No leakage
   - ___ Stool staining
   - ___ Small amount in underwear
   - ___ Complete emptying
7. Protection worn (check all that apply)
   - ___ None
   - ___ Tissue paper / paper towel
   - ___ Diaper
   - ___ Pull-ups

8. Ask your child to rate his/her feelings as to the severity of this problem from 0 to 10.

0	1	2	3	4	5	6	7	8	9	10
Not a problem										Major problem

9. Rate the following statement as it applies to your child's life today:

My child's bladder/bowel is controlling his/her life.

0	1	2	3	4	5	6	7	8	9	10
Not true at all										Completely true

_____ _____

Patient Name (Please Print) Patient Signature

_____ _____

Signature of Parent or Guardian (If applicable) Date