Physical Therapy Consent

Informed Consent and Waiver & Release of Liability

In agreeing to receive care provided by Physical Therapy of Tulsa, LLC ("Physical Therapy of Tulsa"), located at 6767 S Yale Ave. Suite B Tulsa OK 74136, I agree as follows:

I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by Physical Therapy of Tulsa and the equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to, bodily injury, disease, soreness, strains, numbness, tingling, muscle tears, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability; (c) I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of the representatives or employees of Physical Therapy of Tulsa, or by any other person; (d) I know that I have the right to choose what treatment I do or do not receive, in addition to withdrawing from treatment at any time; (e) I recognize that my participation in the activity covered hereby is conditioned upon my signing and returning this waiver and release.

I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Physical Therapy of Tulsa and its representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims that I may have presently or in the future for the negligent acts or other conduct by the representatives or employees of Physical Therapy of Tulsa.

I understand that I may show this INFORMED CONSENT and WAIVER & RELEASE OF LIABILITY to, and consult with, my own independent legal counsel before signing.

Consent: I consent to and authorize Physical Therapy of Tulsa (including students in training) to administer physical therapy treatment under the direction and supervision of the physical therapist. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform the physical therapist/staff about any health problems or allergies I have, as well as medications I am taking.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT AGREE. IT IS MY INTENTION TO EXEMPT PHYSICAL THERAPY OF TULSA FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH BY ANY CAUSE.

_____	_____	_____
Patient/Guardian Signature	**Witness Signature**	**Date**

DISCLOSURE OF HEALTH INFORMATION TO INDIVIDUALS INVOLVED IN PATIENT CARE

In accordance with the provisions of Section 164.510(b) of the Health Insurance Portability and Accountability Act (HIPAA), I agree Physical Therapy of Tulsa and its duly authorized employees may disclose Protected Health Information directly relevant to involvement with my care, or payment related to my care, any other individuals that I may indicate below who may contact *Physical Therapy of Tulsa* on my behalf.

List the name of individual(s), relationship and identify the type of information to be disclosed
PLEASE PRINT

Name	Relation	Type of information
_____	_____	_____

I understand:

- At any time, I may add or remove individuals from this list by notifying Physical Therapy of Tulsa my desire to do so. I understand that until I notify Physical Therapy of Tulsa of requested changes to this list, Physical Therapy of Tulsa may rely on this list and disclose information the individuals listed above.
- Information disclosed to the individuals identified above may be subject to disclosure by the recipient and no longer protected by federal law.

* I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but not limited to, diseases such as, hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (AIDS). My medical information may indicate that I have or have been treated for psychological or psychiatric condition or substance abuse.

Patient/Guardian Signature	Witness Signature	Date
_____	_____	_____

PATIENT AUTHORIZATION FOR TREATMENT AND FINANCIAL STATEMENT

Authorization for Treatment: By virtue of my signature, I consent to services at Physical Therapy of Tulsa. In so doing, I understand, acknowledge and affirm that such services may involve bodily contact, touching, and/or direct contact of a sensitive nature.

Notice of Privacy Practices: I acknowledge that I have reviewed a copy of Physical Therapy of Tulsa's notice of privacy practices and agree to their use and disclosure of my protected health information for treatment, payment and healthcare operations.

Financial Statement: Payment is due immediately upon the provision of services unless a previous arrangement has been made. All patients are required to pay total charges of **$150** at the time one service.

*****MEDICARE Authorization of payment:** I hereby refuse submission of my personal health information, medical records and billing information from being sent to my insurance company under any circumstance. This decision is of my own free will and under no guidance of any other person. I understand that I am fully responsible for all financial obligations to Physical Therapy of Tulsa and cannot submit for reimbursement from my insurance company.

_____
Initials

Signature: By virtue of my signature below, I hereby acknowledge that I have read and understand all of the above, I agree to be bound by all of PTOT's payment policies and that I have been given adequate opportunity to ask questions about the same.

Patient/Guardian Signature	Witness Signature	Date
_____	_____	_____

PATIENT CANCELLATION AND NO SHOW POLICY

In order to provide you with the best care possible we ask that you agree to this policy and make every effort to keep your scheduled appointments and arrive in a timely manner.

We request a valid credit card number to be kept on file at the time of scheduling your initial visit. In the event of late arrivals and no show appointments, you will be subject to the full fee for the session. We require 24-hour notice for cancellations. Appointments that are cancelled with less than 24 business hours' notice are subject to a charge of **60%** of the appointment fee, which is not reimbursable by insurance companies.

This policy has been established in order to provide the highest level of Physical Therapy Service to all of our patients. It has been proven that consistent attendance provides for the greatest opportunity for success. By providing us notice of a cancellation, we may be able to accommodate other patients with your appointment slot.

We do understand that emergencies arise and that it may not be possible to give such a notice.
Exceptions to the No-Show/Late Cancellation Policy will be determined by the Director of Rehabilitation.

If you need to reschedule or cancel an appointment please call us as soon as you know you cannot make your scheduled appointment. We can be reached by phone at 918-494-3000.

_____ _____ _____

Patient/Guardian Signature **Witness Signature** **Date**

At Physical Therapy of Tulsa we require keeping your credit or debit card on file as a convenient method of payment for services rendered. Your account information is kept confidential and secure. My card will be processed at the time of check-in or under circumstances that I have been notified (i.e. No Call-No show appointments). For such circumstances as a no show appointment I will be notified by a representative at Physical Therapy of Tulsa of the time and amount that I am responsible for.

I authorize Physical Therapy of Tulsa to charge the following credit or debit card for charges I am responsible for and have agreed to pay. These charges will not exceed $150 per visit.

☐ Amex ☐Visa ☐Mastercard ☐Discover

Credit Card Number _____ **Expiration Date**_____**CVV**_____

Billing Address _____ _____ _____ _____

City **State** **Zip**

Cardholder Name _____

Printed as it appears on card

Signature of card holder _____

I, the undersigned, authorize and request Physical Therapy of Tulsa to charge my card as indicated above for services from Physical Therapy of Tulsa. This authorization relates to all payments and charges I have been made aware of for services to be received at Physical Therapy of Tulsa. This authorization will remain in effect until I cancel this authorization. To cancel I understand I must provide a written request to Physical Therapy of Tulsa and my account must be in good standing.

_____ _____ _____

Patient/Guardian Signature **Witness Signature** **Date**

PHYSICAL THERAPY OF TULSA

First Name _____ Last Name _____ Date of Birth ____/____/____ Social Security ___-___-____

Home Phone (____) _____ Cell Phone (____) _____ Gender _____ Marital status _____

Home Address _____ City _____ State _____ Zip _____

Email * *Please print legibly* _____

How would you like to be reminded about your Appointments?
☐ E-Mail ☐ Text Message ☐ Voice call (Home/ Cell)

Emergency Contact _____ Phone (____) _____ Relationship _____

Who can we thank for referring you to the clinic? _____

I certify that all of the information provided here is true and correct. I understand I am responsible for any charges that may occur due to incorrect information given here.

Patient/Guardian Signature _____ **Witness Signature** _____ **Date** _____

Patient Medical History

Current work status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Unemployed ☐ Disability ☐ Retired ☐ Other _____

Do you use tobacco? ☐ Yes ☐ No **If "Yes," how often?** _____

How would you rate your overall health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Are you pregnant or is there a possibility you could be pregnant? ☐ Yes ☐ No

What tests have you had? ☐ X-Ray ☐ CT Scan ☐ MRI ☐ EMG ☐ PET Scan ☐ Ultrasound ☐ Venous Doppler ☐ Angiogram ☐ Urodynamics ☐ Cystoscopy ☐ Other _____

What surgeries have you had? (Check all that apply) ☐ check here if you have attached a separate sheet

☐ Cataract ☐ Gallbladder ☐ Prostate ☐Carpal Tunnel ☐ Tonsillectomy ☐ Hernia ☐ Joint ☐ Heart Bypass

☐ Open Heart ☐ Skin Graft ☐ Back ☐ Neck ☐ Bladder ☐ D & C ☐ Splenectomy ☐ Appendectomy

☐ Breast Surgery ☐Tubal Ligation ☐ C-Section ☐ Episiotomy ☐ Hysterectomy ☐ Colon/Bowel/Intestine

☐ Kidney ☐ Thyroidectomy ☐ Fracture Repair and Locations: _____

☐ All other Pelvic or Abdominal Surgeries With Date of Operation (When Possible)

_____

_____

 Provider Reviewed: _____

Name: _____ Date of Birth:_____

Past Medical History (Check all that apply): ☐ Check if you have attached a separate sheet

☐ MRSA ☐ Diabetes ☐ Hypertension ☐ Mitral Valve Prolapse ☐ Heart Attack ☐ Congestive Heart Failure

☐ DVT/Clots ☐ Irregular Heartbeat ☐ Pacemaker ☐ Internal Defibrillator ☐ Asthma ☐ COPD ☐ Emphysema

☐ Chronis Bronchitis ☐ Tuberculosis ☐ Frequent Heartburn ☐ Gastric Reflux ☐ Hiatal Hernia ☐ Cirrhosis

☐ Hepatitis ☐ Gallbladder Disease ☐ Stomach Ulcer ☐ Thyroid Disease ☐ Kidney Stone(s) ☐ Kidney Infection

☐ Kidney Dialysis ☐ Anemia ☐ Bruising ☐ HIV/AIDS ☐ Stroke/TIA ☐ Epilepsy/Seizures ☐ Alzheimer's

☐ Parkinson's Disease ☐ Headaches ☐ Restless Leg Syndrome ☐ Fibromyalgia ☐ Spinal Cord Injury

☐ Artificial Joint ☐ Arthritis ☐ Depression ☐ Anxiety ☐ Mental Illness ☐ Metal Implants ☐ Osteoporosis

☐ Vitamin Deficiency ☐ Other _____

Do you currently have or have you had cancer? ☐ Yes ☐ No (if "No," skip to "Allergies")

What type of cancer? _____ **How is it being treated?** _____

Allergies (Please list all): _____

_____

Current Medications: ☐ Check if you have attaches a separate sheet

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Provider Reviewed: _____

Name: _____ Date of Birth:_____

What Issues are you seeking help for from physical therapy? _____

_____

When did it begin? _____ **Is it getting:** ☐ Better ☐ Worse ☐ Staying the same

Who else have you seen for this issue (check all that apply)? ☐ No one ☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist ☐ Occupational Therapist ☐Massage Therapist ☐ Physiatrist ☐ Athletic Trainer ☐ Nutritionist ☐ Other: _____

IF <u>BOWEL</u> OR <u>BLADDER LEAKAGE</u> is a problem for you, please answer the following questions in PART A, if not please skip to PART B

<u>PART A</u>

Occurrence of Incontinence or Leakage: ☐ Less than 1x/month ☐ More than 1x/month ☐ Less than 1x/week ☐ More than 1x/week ☐ Almost every day ☐ ____# of leaks per day

Protection Used: ☐ No protection ☐ Pantisheild ☐ Mini pad ☐ Maxi pad ☐ Diaper

Severity: ☐ Few drops ☐ Wet underwear ☐Wet outerwear

Position of Activity with Leakage: ☐ Lying down ☐ Sitting ☐ Standing ☐ Changing positions (sit to stand) ☐ Sexual activity ☐ Strong urge ☐ Coughing, sneezing, bending

Activity that Causes Leakage: ☐ Vigorous activity ☐ Moderate activity ☐Light activity

<u>PART B</u>

Prolapse (feeling of falling out): ☐ Never ☐ Occasionally/with menses ☐ Pressure at the end of the day ☐ Pressure with straining ☐ Pressure with standing ☐ Pressure all day

How long can you delay the need to urinate? ☐ Indefinitely ☐ 1+ Hours ☐ ½ Hour ☐ 15 minutes ☐ Less than 10 minutes ☐ 1-2 minutes ☐ Not at all

Frequency of Urination (Daytime): ☐ 1-4 times/day ☐ 5-8 times/day ☐ 9-12 times/day ☐ ____# times/day

Frequency of Urination (Nighttime): ☐ 0 times/night ☐ 1 time/night ☐ 2 times/night ☐ 3 times/night

 Provider Reviewed: _____

Name: _____ **Date of Birth:**_____

PART B Continued

Frequency of Bowel Movements: ☐ 2 times/day ☐ 1 time/day ☐ Every other day ☐ once every 4-7 days

After Starting to Urinate, Can you Completely Stop the Urine Flow?

☐ I can stop completely ☐ I can maintain deflection of urine stream

☐ I can partially deflect urine stream ☐ I am unable to deflect or slow the urine stream

Do You Have Trouble Initiating Urine Stream?

☐ Never ☐ More than 1/month ☐ Less than 1x/month ☐ Daily

Do You Have Pain or Problems With Sexual Activity?

☐ This does not apply to me, as I am not sexually active

☐ No pain during sexual activity

☐ Yes, I have pain with sexual activity

Describe _____

Do You Have Pain or Problems With Urination?

☐ No pain with urination

☐ Yes, I have pain with urination

Describe _____

Do You Have Pain or Problems With Bowel Movements?

☐ No pain with bowel movements

☐ Yes, I have pain or problems with bowel movements

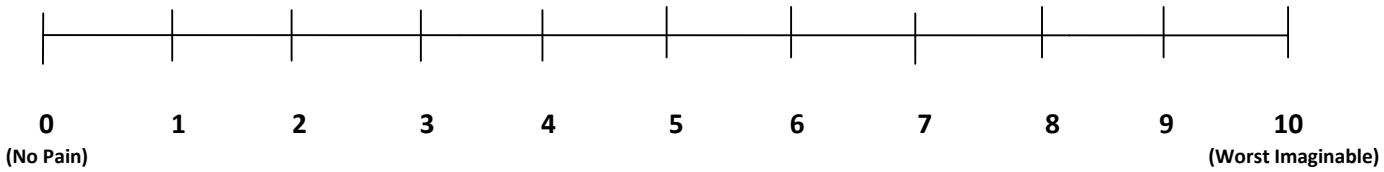
Describe _____

 Provider Reviewed: _____

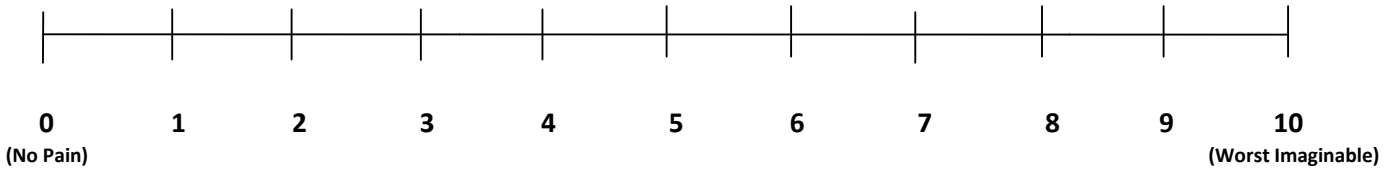
PHYSICAL THERAPY OF TULSA

Name: _____ **Date of Birth:**_____

Please rate your Pain today (if applicable)



Please rate your pain at its best (lowest) and at its worst (highest) (if applicable):



Please indicate the location of your symptoms on the diagram. Use the key below to indicate the kind of symptoms you are having.

Sharp: ^^^^

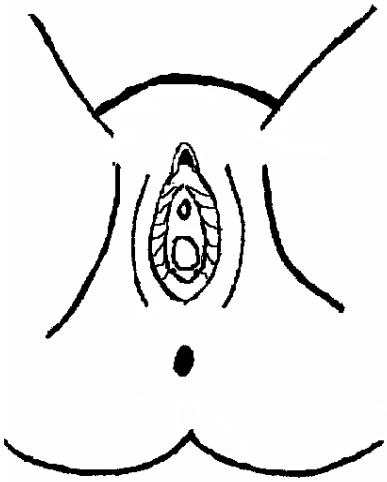
Shooting: ↓↓↓↓

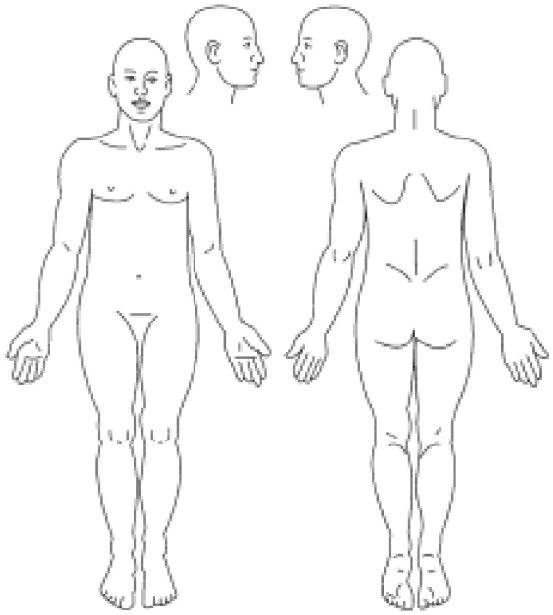
Dull Ache: OOOO

Burning: XXXX

Numbness/Tingling: ////

Other: ++++





Please tell us what things you would like to return to doing that you are having difficulty doing now.

_____

_____

Provider Reviewed: _____

PHYSICAL THERAPY OF TULSA

Name: _____ **Date of Birth:**_____

PFIQ – 7 Instructions: Some women find that bladder, bowel, or vaginal symptoms affect their activities, relationships, and feelings. For each question place an **X** in the response that best describes how much your activities, relationships, or feelings have been affected by your bladder, bowel, or vaginal symptoms or conditions **over the last 3 months**. Please make sure you mark an answer in all 3 columns for each question.

How do symptoms or conditions relating to the following → → → Usually affect your ...↓	***Bladder or urine***	***Bowel or rectum***	***Vagina or pelvis***
1. Ability to do household chores (cooking, housecleaning, laundry)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
2. Ability to do physical activities such as walking, swimming, or other exercise?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
3. Entertainment activities such as going to a movie or concert?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
5. Participating in social activities outside your home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
6. Emotional health (nervousness, depression, etc.)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
7. Feeling frustrated?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

Provider Reviewed: _____

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All of the items use the following response scale:

0 = not at all; 1 = somewhat, 2 = moderately, 3 = quite a bit

Scales:

Urinary Impact Questionnaire (UIQ-7); 7 items under column heading “Bladder or urine.” Colorectal-Anal Impact Questionnaire (CRAIQ-7): 7 items under column heading “Bowel or rectum.”

Pelvic Organ Prolapse Impact Questionnaire (POPIQ-7): 7 items under column heading “Pelvis or vagina.”

Scale scores: Obtain the mean value for all of the answered items within the corresponding scale (possible value 0 to 3) and then multiply by 100/3) to obtain the scale score (range 0 to 100). Missing items are dealt with by using the mean from answered items only.

Total score of each section _____ divided by 7 _____ X 33.3 =

PFIQ-7 Summary Score: Add the scores from the 3 scales together to obtain the summary score (range 0 to 300).

Barber, M., Walters, M., et al. (2005). "Short forms of two condition-specific quality of life questionnaires for women with pelvic floor disorders (PFDI-20 and PFIQ -7)." American Journal of Obstetrics and Gynecology 193: 103-113.

Provider Reviewed: _____

Name: _____ **Date of Birth:**_____

At Physical Therapy of Tulsa we appreciate your time and we know you have a lot of paperwork to fill out. We use this information to help us give you the best and most complete care possible. Thank you for answering the following questions to the best of your ability.

Have you recently experienced any of the following:

Abnormal sensations (e.g. numbness, pins and needles)?	Yes	No
Headaches?	Yes	No
Night pain?	Yes	No
Sustained morning stiffness?	Yes	No
Light-headedness?	Yes	No
Trauma (e.g. car accident, fall)?	Yes	No
Night sweats?	Yes	No
Changes in bowel/ bladder (e.g. constipation, frequency, incontinence)?	Yes	No
Easy bruising?	Yes	No
Changes in vision?	Yes	No
Changes in menstruation patterns?	Yes	No
Gait or balance disturbances?	Yes	No
Chest pain with rest?	Yes	No
Shortness of breath?	Yes	No
Muscle weakness?	Yes	No
Failure of conservative intervention (failure to improve within 30 days)?	Yes	No
Excessive sweating?	Yes	No
Edema (swelling) or weight gain?	Yes	No
A heartbeat in your abdomen when you lie down?	Yes	No
Cramps in your legs when you walk for several blocks?	Yes	No
Abdominal pain?	Yes	No
Changes in the integrity of your nails?	Yes	No
Prolonged use of corticosteroids?	Yes	No
Feeling down, depressed, or hopeless?	Yes	No
Being bothered by little interest or pleasure in doing things?	Yes	No

Provider Reviewed: _____