ORTHOPEDIC SPINE THERAPY

Welcome

We hope this message finds you well. We wanted to take a moment to provide you with some information about what to expect from pelvic health physical therapy.

Pelvic health therapy is a specialized branch of physical therapy that focuses on the treatment of conditions related to the pelvic region. This can include issues such as pelvic pain, urinary incontinence, pelvic organ prolapse, and sexual dysfunction, among others.

During your first visit, you can expect to have a thorough evaluation with a pelvic health physical therapist. They will take the time to understand your medical history, symptoms, and any concerns you may have. This evaluation may involve a physical examination, which could include assessing your posture, muscle strength, flexibility, and coordination in the pelvic region. An internal examination will not be performed on initial evaluation without education, discussion and consent.

Based on the findings from the evaluation, your therapist will work with you to develop a personalized treatment plan. This plan may include a combination of manual therapy techniques, exercises, and education on self-care strategies. The goal of pelvic health physical therapy is to help you regain function, reduce pain, and improve your overall quality of life.

It's important to note that pelvic health physical therapy is a collaborative process. Your therapist will work closely with you to ensure that your treatment plan is tailored to your specific needs and goals. They will also provide ongoing support and guidance throughout your journey to recovery.

If you have any questions or concerns, please don't hesitate to reach out to your pelvic health physical therapist. They are there to help you every step of the way.

Wishing you all the best on your path to pelvic health!

Warm regards,

Your Orthopedic & Spine Therapy Pelvic Health Team

HIPAA WRITTEN ACKNOWLEDGEMENT OF RECEIPT
NONDISCRIMINATION POLICY

I acknowledge that I have received from Orthopedic & Spine Therapy a written notice of Orthopedic & Spine Therapy's privacy practices from protected health information. I acknowledge that the written notice contains a description of how medical information about me may be used and disclosed and how I may access this information. I acknowledge that the notice also contains:

- A description of the types of uses and disclosures that Orthopedic & Spine Therapy is permitted to make for treatment, payment, or health care operations with and without my written authorization.
- A description of each of the other purposes for which Orthopedic & Spine Therapy is permitted or required to use or disclose protected health information without my written authorization.
- A description of uses or disclosures that may be limited or prohibited by law.
- The description contains sufficient detail to make me aware of the use or disclosures that are permitted or required by the federal privacy rule and other applicable law.
- A statement describing my individual rights with respect to my health information and a description of how I may exercise this right.
- A statement describing the Orthopedic & Spine Therapy duties under the federal privacy law.
- A statement describing how I may express concern to the Orthopedic & Spine Therapy and the Secretary of the Department of Health and Human Services if I believe my privacy rights have been violated.
- I have received information explaining how to contact Orthopedic & Spine Therapy for further information and the effective date which the notice is first in effect.
- I understand and agree that testimonials or comments that I share may be used at Orthopedic & Spine Therapy's discretion for promotional material, digital advertising, and/or their website.

I, _____, acknowledge that I have received the written notice of Privacy Practices from Orthopedic & Spine Therapy.

_____ _____

Patient Signature Date

As a recipient of Federal financial assistance, Orthopedic & Spine Therapy does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities.whether carried out by OST directly or through a contractor or any other enchy with which OST arranges to carry out its programs and activities.

This statement is in accordance with the provision of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Regulations of the US Department of Health and Human Services issued pursuant to these statutes of Title 45 Code of Federal Regulations Part 80, 84, and 91.

In case or questions, please contact: Orthopedic & Spine Therapy, Amy Barnett. 920.257.2005

Financial/Consent to Treat Policy

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. The following is our Financial/Consent to Treat Policy statement, which we require you to read and sign before treatment. If at any time you have questions regarding any treatment, fees, or services please discuss them with us.

REGARDING INSURANCE: As a courtesy to you, we will bill your insurance carrier. Please be aware some and perhaps all services may be "noncovered" and are not considered reasonable and necessary under some medical insurance policies. Also, we charge what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates. Co-pays are due at the time of your appointment.

MEDICARE: We do accept assignments for Medicare. There are certain guidelines that we, as an independent physical therapy practice, are required to follow. You agree to authorize payment of Medicare benefits to Orthopedic & Spine Therapy for any services furnished. In addition, you agree to authorize payment of Medicare benefits to Orthopedic & Spine Therapy for any services furnished.

WORKERS' COMPENSATION: In the case of a work-related claim, we will bill the appropriate workers' compensation carrier. If the claim is unsettled or unpaid within 60 days, you will receive a statement from our office. If the claim is denied, you will receive notice from the workers' compensation carrier. Upon notification, we will bill you or your personal health insurance carrier. Documentation of any missed appointments is forwarded to your Case Manager and Primary Physician, which could jeopardize your claim. Additionally, I agree to authorize OST to forward my medical records with all claims to work comp carriers and/or employers to assist in claims processing.

INJURIES/ACCIDENTS INVOLVING LEGAL LITIGATIONS: We will not bill third-party insurance if your injury or accident involves legal litigation; however, we will bill you or your health insurance. We will require you to make payments on the charges even if the third party will cover them. Documentation of any missed appointments is forwarded to your Case Manager and Primary Physician, which could jeopardize your claim.

CANCELLATIONS/NO-SHOWS: We require a 24-hour notice in the event of a cancellation. There is a $50 charge per 40-minute appointment for cancellation without proper notice or failure to show for your scheduled appointment. This charge will not be covered by insurance and the patient/responsible party will be financially responsible for the balance. Additionally, if you fail to show or cancel more than two times during treatment, OST reserves the right to discharge you from care.

NON-SUFFICIENT FUNDS (NSF) CHECKS: There is a $50 charge for returned checks with insufficient funds.

COLLECTION AGENCY PLACEMENT POLICY: You are financially responsible for the timely payment of your outstanding bill per our payment policies. You will be responsible for any and all collection agency fees up to 30% of the amount placed with the collection agency. In the event we seek legal action for the collection of your account, you will also be responsible for actual fees associated with the court costs, garnishments, and/or attorney fees.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION/ASSIGNMENT OF BENEFITS: You hereby authorize Orthopedic & Spine Therapy to provide treatment, release information pertaining to your treatment for insurance purposes, and/or to receive direct insurance payments otherwise payable to you for services rendered.

CONSENT TO TREAT: There are potential risks and benefits of physical therapy treatment. Potential benefits include an improvement in your symptoms and/or an increase in your ability to perform daily activities. You may experience increased strength, awareness, flexibility, and endurance in your movements. You will have a greater knowledge of managing your condition and the resources available to you. Potential risks may be due to the many movements and positions that are performed. It is not uncommon to experience temporary discomfort after treatment. Any concerns should be addressed with your therapist. **Supplies: During the course of treatment, there may be supplies that will be beneficial to your treatment. These are sold on a cash basis and not billed to your insurance. Pricing will vary by item.** Therapy will be most effective when you are compliant with your treatment plan as outlined by your physical therapist.
If you have questions or problems, please let us know and we will be happy to assist you in every way possible.

I have read the Financial/Consent to Treat Policy. I understand and agree with this policy.

_____ _____

(Patient or Responsible Party Signature) (Date)

ORTHOPEDIC SPINE THERAPY

Pelvic Health Intake Form

Name _____ Date _____

DOB _____ Age _____

What is your gender? _____ What sex were you assigned at birth? _____

URINARY FUNCTION

I estimate _____ urinations per day & _____ per night.

I leak urine when I:
☐ cough ☐ yell ☐ exercise ☐ move from sitting to standing ☐ sneeze ☐ jump ☐ laugh ☐ vomit ☐ other _____

I constantly leak urine: ☐ Yes ☐ No ☐ Sometimes

I am unable to make it to the toilet in time because the urge is so strong that I leak urine:
☐ Yes ☐ No ☐ Sometimes

Things that trigger my urge include: ☐ running water ☐ cold ☐ key in the door ☐ the bathroom ☐ other _____

I have a ☐ constant stream ☐ intermittent stream **of urine when I urinate.**

I have difficulty ☐ starting ☐ stopping **my flow.**

I have to ☐ strain ☐ self-cath ☐ none **to completely empty my bladder.**

I empty my bladder when I urinate: ☐ Yes ☐ No ☐ Sometimes

I wear pads for my urinary incontinence: ☐ Yes **How Many?** _____ ☐ No ☐ Sometimes

I do pelvic floor exercises (kegels): ☐ Yes ☐ No ☐ Sometimes

BOWEL FUNCTION

I typically have _____ bowel movements per ☐ week ☐ day

I leak: ☐ gas ☐ stool ☐ none

I wear pads for my fecal incontinence: ☐ Yes **How Many?** _____ ☐ No ☐ Sometimes

I have irritable bowel syndrome: ☐ Yes ☐ No

I typically have ☐ constipation ☐ diarrhea ☐ mixed

To manage constipation I use _____

I am unable to make it to the toilet in time because the urge is so strong that I leak feces:
☐ Yes ☐ No ☐ Sometimes

Things that trigger my urge include: ☐ eating ☐ cold ☐ key in door ☐ caffeine ☐ running water ☐ the bathroom ☐ other _____

I have to splint my perineum with my hand when I have a bowel movement:
☐ Yes ☐ No ☐ Sometimes

I have to manually evacuate stool on occasion: ☐ Yes ☐ No ☐ Sometimes

I am experiencing rectal bleeding and/or blood in my stool: ☐ Yes ☐ No ☐ Sometimes

ORTHOPEDIC SPINE THERAPY

NUTRITION, FLUID & EXERCISE INTAKE

I drink _____ servings of water per day. *(1 serving = 8 ounces)*

I drink the following servings of beverages a day:

☐soda_____ ☐decaf coffee_____ ☐diet soda_____ ☐tea_____
☐milk_____ ☐alcohol_____ ☐regular coffee____ ☐other____

I weigh _____ pounds

I am currently dieting: ☐ Yes **What diet? _____** ☐ No

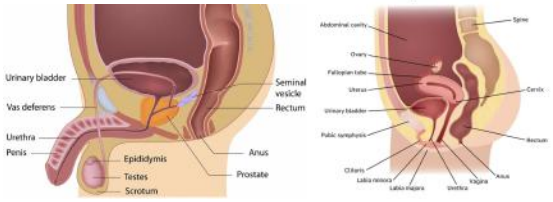
I exercise _____ times per week.

I typically do the following exercises: _____

I have had/have an eating disorder: ☐ anorexia ☐ bulimia ☐ none ☐ other _____

PAIN & SEXUAL HEALTH HISTORY

Please circle the areas of pain on the pictures below. Rate your pain on a scale of 1-10 at the site(s) of pain. (10 = most severe)



I have problems with pain: ☐ Yes ☐ No ☐ Sometimes
I am sexually active at this time: ☐ Yes ☐ No ☐ Sometimes
I am sexually inactive due to pain: ☐ Yes ☐ No ☐ Sometimes
I am sexually inactive for other reasons: ☐ Yes ☐ No ☐ Explain _____

Please answer the following if it applies to you:

Biological Female:

My pain is worse with ovulation: ☐ Yes ☐ No ☐ Sometimes
I have pain during my period: ☐ Yes ☐ No ☐ Sometimes

I have pain during intercourse: ☐ my pain feels close to the vaginal opening ☐ pain with orgasm ☐ my pain feels deep inside me ☐ other_____

I have pain after intercourse: ☐ when my bladder is full ☐ burning vaginal pain after sex ☐ backache ☐ pain with sitting ☐ muscle/joint pain ☐ pain with urination ☐ migraine ☐other_____

Biological Male:

My pain is worse during an erection: ☐ Yes ☐ No ☐ Sometimes
My pain is worse during ejaculation: ☐ Yes ☐ No ☐ Sometimes
My pain lingers after ejaculation for _____ ☐ days ☐ hours ☐ minutes
My pain is located: ☐ rectal area ☐ penis ☐ testicles ☐ my pain feels deep inside ☐ abdomen ☐ behind testicle ☐ buttock

I have pain after intercourse. This pain includes:
☐ backache ☐ when my bladder is full ☐ pain with sitting ☐ muscle/joint pain ☐ pain with urination ☐ migraine headache ☐ other _____

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Please answer the following if it applies to you:

GYNECOLOGICAL HISTORY

The first day of my last menstrual cycle was: _____

Have you currently started your menstrual cycle? ☐ Yes ☐ No

During menstruation, my periods are: ☐ light ☐ heavy ☐ moderate ☐ bleed through protection

I have ☐ started ☐ not started ☐ completed **menopause**

Do you use birth control? ☐ Yes ☐ No

I am currently using the following birth control method: ☐ IUD ☐ birth control pill ☐ Nuva Ring ☐ condoms ☐Depo Provera shot ☐withdrawal ☐ other _____

Do you have history or a current medical concern? (including pelvic heaviness, fibroids, cysts, or endometriosis)

_____

OBSTETRIC HISTORY

Number of pregnancies: _____ (including current, if applicable)
vaginal deliveries _____ miscarriages _____
cesarean deliveries _____ abortions _____ episiotomies_____

What complications did you experience during pregnancy during labor, delivery, or postpartum?
☐ vacuum ☐ medication for bleeding ☐ forceps ☐ postpartum hemorrhaging ☐ perineal tearing ☐ postpartum depression ☐ preeclampsia ☐ other_____

I am currently pregnant: ☐ Yes ☐ No

If answered no, please skip this section.

I'm at _____ weeks gestation, with the due date of _____

Do you have concerns during this pregnancy?

_____

Has your physician placed you on any restrictions?

_____

Fill out this section ONLY if you have given birth in the last 12 weeks.

IN THE LAST 7 DAYS
I have blamed myself unnecessarily when things go wrong: ☐ yes, all the time ☐ yes, most of the time ☐ no, not very often ☐ no, not at all

I have felt panicky or scared for no good reason: ☐ yes, all the time ☐ yes, most of the time ☐ no, not very often ☐ no, not at all

I have been anxious or worried for no good reason: ☐ yes, all the time ☐ yes, most of the time ☐ no, not very often ☐ no, not at all

ORTHOPEDIC SPINE THERAPY

Patient Intake Form

Name _____ **Date Of Evaluation** _____

DOB _____/_____/_____ **Age** _____

It is important for us to know how our patients hear about us. Who can we thank for your referral to OST?
☐ MD/NP ☐ Family ☐ Friend *(optional, provide name)* _____ ☐ Newsletter ☐ Employer ☐ Social Media
☐ Linkedin ☐ Advertisement ☐ Magazine ☐Community Talk ☐ Website ☐Other _____

Email _____ **Next MD Visit** ___/___/___ **Referring MD**_____

Family MD _____**Occupation**_____ **Job Description**_____

Work Status: ☐ Full-time ☐ Full-time, with restrictions ☐ Part-time ☐ Part-time, with restrictions
☐ Not Working/Retired ☐ Maternity Leave ☐ Medical Leave ☐ Other _____

Living Situation: ☐ House ☐ Apartment **Do you feel safe at home?** ☐ Yes ☐ No ☐ _____

Leisure Activities _____
How do you learn best? ☐ Listening ☐ Seeing ☐ Doing ☐ Comment _____

What specific issues do you want addressed? _____

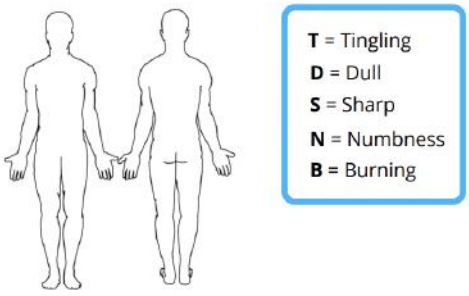
When did your problem develop? Exact Date ___/____/_____

How did your problem begin? _____

Since your problem began, is it: ☐ Improving ☐ Staying the same ☐ Worsening

Are you right hand or left hand dominant? ☐ Right ☐ Left **Is your pain:** ☐ Consistent ☐ Intermittent

Please note on the diagram where you're experiencing pain, using the appropriate letters below:



Rate your pain: 1 - 10 (10 being extreme): At present: _____ **At best:** _____ **At worst:** _____

PERSONAL GOALS

List and score at least 3 activities that you are unable to perform or have the most difficulty performing because of your chief complaint.

On a 0-10 scale, the HIGHER the number, the EASIER. The LOWER the number, the more DIFFICULTY you have. 0 = unable to perform activity ; 10 = fully able to perform activity

Activity: _____ **Score:** _____

Activity: _____ **Score:** _____

Activity: _____ **Score:** _____

Are there any activities or positions that significantly *worsen* your symptoms?

☐ Sitting ☐ Walking ☐ Lying Down ☐ Ice ☐ Intercourse ☐ Coughing/sneezing ☐ Standing
☐ Lifting ☐ Bending ☐ Heat ☐ Other _____ ☐ Bowel/bladder movements

Are there any activities or positions that significantly *improve* your symptoms?

☐ Sitting ☐ Walking ☐ Lying Down ☐ Ice ☐ Intercourse ☐ Coughing/sneezing ☐ Standing
☐ Lifting ☐ Bending ☐ Heat ☐ Other _____ ☐ Bowel/bladder movements

Are you currently receiving the following treatment with another provider?

☐ Physical Therapy ☐ Home healthcare ☐ Nursing facility services ☐ Chiropractic ☐ Massage

Have you had prior treatment(s) for this condition?

☐ Physical Therapy ☐ Injections ☐ Surgery ☐ Chiropractic ☐ Massage ☐ Acupuncture
☐ Other _____

Have you had any recent diagnostic tests?

☐ Bone scan ☐ EMG ☐ Urodynamics ☐ X-Ray ☐ CT scan ☐ Urinalysis ☐ MRI
☐ Other _____

Please list all allergies:

☐ Seasonal ☐ Medications ☐ Latex ☐ Food ☐ Nickel ☐ Environmental ☐ Other _____

Please list all medications you are currently taking (or attach list) :

_____

At the present time, would you say that your health is: ☐ Excellent ☐ Very Good ☐ Fair ☐ Poor

Past Surgical History *(please include dates to the best of your ability):*

☐ Joint replacement _____
☐ Spinal fusion _____
☐ Laminectomy/discectomy_____
☐ Shoulder surgery_____
☐ Elbow/hand/wrist surgery _____
☐ Hip surgery _____
☐ Knee surgery _____
☐ Ankle/foot surgery _____
☐ Hernia repair _____

☐ Cesarean section_____
☐ Hysterectomy_____
☐ Appendix removal _____
☐ Gallbladder removal_____
☐ Abdominal surgery_____
☐ Laparoscopy_____
☐ Bladder surgery_____
☐ Prostate surgery_____
☐ Hemorrhoid surgery_____
☐ Implanted devices_____

☐ Gastric bypass_____
☐ Ileostomy_____
☐ Colostomy_____
☐ Vasectomy_____
☐ Coccyx removal_____
☐ Abortion_____
☐ D&C_____
☐ Prostate surgery_____
☐ Pudendal nerve surgery_____
☐ Other_____

Please check *all conditions* below that apply to you:

HEART & CIRCULATION	BONES & JOINTS	LUNGS & BREATHING
☐ High blood pressure ☐ Pain/tightness in the chest ☐ Cold hands/feet ☐ Numbness in hands/feet ☐ Anemia ☐ Blood clots ☐ Easy bleeding ☐ Heart attack ☐ Pacemaker ☐ Bypass surgery ☐ Heart murmur ☐ Other _____	☐ Chronic fatigue syndrome ☐ Arthritis ☐ Rheumatoid arthritis ☐ Fibromyalgia ☐ Tailbone pain ☐ Osteoporosis ☐ Easy bleeding ☐ Stress fracture ☐ Joint replacement ☐ Bypass surgery ☐ Scoliosis ☐ Other _____	☐ Shortness of breath ☐ Currently Smoking ☐ History of smoking ☐ Asthma ☐ Emphysema/bronchitis ☐ COPD ☐ Other_____

SKIN CONDITIONS	OTHER MEDICAL CONDITIONS	OTHER MEDICAL CONDITIONS
☐ Eczema ☐ Contact Dermatitis ☐ Lichens Sclerosis ☐ Psoriasis ☐ Other_____	☐ Diabetes ☐ Cancer ☐ Melanoma ☐ Lupus ☐ Stroke ☐ Hearing Loss ☐ Ringing in ears ☐ Vision/eye problems ☐ Dizziness ☐ Depression ☐ Anxiety ☐ Prolapse ☐ Incontinence ☐ Headaches ☐ Hyperthyroid ☐ Hypothyroid	☐ Head injury ☐ Epilepsy/seizures ☐ Multiple sclerosis ☐ Irritable bowel syndrome ☐ Ulcers ☐ Hernia ☐ Kidney problems ☐ Hepatitis ☐ Alcohol/drug addiction ☐ Vomiting ☐ Unexplained weight change ☐ Sweating ☐ Chills ☐ Sexually transmitted disease ☐ Falls in the last 6 months ☐ Metal implants ☐ Breast implants ☐ HIV/AIDS ☐ Other _____

Please explain any checked items in the chart and add others not listed.

_____

What do you hope to accomplish in physical therapy?

_____

Patient Signature _____ Date ___/_____/_____ PT Initials _____