NEW PATIENT INFORMATION

Who can we thank for referring you to us? Check all that apply:

- ☐ Physician
- ☐ Friend/Word of Mouth: ______________________
- ☐ Google Search
- ☐ Worker's Compensation
- ☐ Case Manager/Discharge Planner
- ☐ Other: _____________________

NORTH RIVER THERAPY PATIENT INFORMATION	
PREFERRED METHOD FOR APPOINTMENT REMINDERS: (CIRCLE ONE): EMAIL VOICE TEXT PLEASE INDICATE WHICH EMAIL/NUMBER TO USE. ______________________________________	Are you currently receiving Home Health? YES NO - If YES, with whom? _________________________ Have you received Home Health in the past 30 days? YES NO - If YES, with whom? __________________________ Have you received physical therapy this year? YES NO

PATIENT INFORMATION		
Last Name:	**First:**	**Middle:**
D.O.B. _______/________/__________	**Gender:** Male Female	
Address:	**City:**	**State:** **Zip:**
Home Phone #: (______)-_______-__________	**Cell Phone #:** (______)-_______-_________	**Email Address:**
INSURANCE INFORMATION		
Policy Holder (if different from patient):	**Relationship to patient:**	**Policy Holder D.O.B. (if different from patient):**

EMERGENCY CONTACT		
Name:	**Relationship:**	**Phone #:**

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RELEASE OF INFORMATION

I, _____________________________, authorize North River Therapy to use, release or disclose my healthcare information for treatment, payment or for healthcare operations to the following family members and friends. This authorization will remain in effect unless revoked by me in writing.

NAME	RELATIONSHIP	PHONE NUMBER
1.________________________	________________	______________________
2.________________________	________________	______________________
3.________________________	________________	______________________

____

Signature Date

PHOTO RELEASE

I hereby grant permission to North River Therapy to use photographs and/or videos of me taken at North River Therapy in publications, news releases, online, social media, and in other communications related to the mission of North River Therapy.

____

Signature Date

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Name: ______________________________ Referring Physician: ______________________________

When did your problem first begin: ____________ Previous treatment: **YES** **NO**

Describe your current symptoms: ____

____

Rate your current pain 0-10: __________ __________ __________

(0 is no pain & 10 is unbearable) at worst current at best

Activities/events that cause or aggravate your symptoms. Check/circle all that apply

___ Sitting greater than ____ minutes

___ Walking greater than _____ minutes

___ Standing greater than _____ minutes

___ Changing positions (ie. - sit to stand)

___ Light activity (light housework)

___ Vigorous activity/exercise (run/weight lift/jump)

___ Sexual activity

___ Other, please list ______________________________

___ With cough/sneeze/straining

___ With laughing/yelling

___ With lifting/bending

___ With cold weather

___ With triggers -running water/key in door

___ With nervousness/anxiety

___ No activity affects the problem

What relieves your pain? (rest, medication, etc.): ____

Please circle only those that apply.

Anemia

Anxiety/Panic Attack

Anorexia/bulimia

Artificial Joints

Bladder/Bowel Incontinence

Bleeding/Bruising

Blood Disorders

Cancer/Tumors/Growths

Chest Pains/Heart Attack

Childhood Bladder Problems

Chills/Fever

Chronic Fatigue Syndrome

Chronic/Migraine Headaches

Concussion

Depression

Diabetes

Diarrhea/Nausea/Vomiting

Emphysema/Asthma

Fibromyalgia

Hepatitis/HIV/AIDs

High Blood Pressure

High Cholesterol

History of Smoking

Kidney Disease/Stones

Latex sensitivity

Lightheadedness/Dizziness

Low Back Pain

Lung Problems

Multiple Sclerosis

Osteoporosis

Pacemaker

Pelvic Pain

Physical or Sexual Abuse

Pregnant

Seizures/Epilepsy

Sexually Transmitted Disease

Shortness of Breath

Spinal Cord Injury

Stroke

Thyroid Problems

Traumatic Brain Injury

Unexplained Weight Loss

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Drug Allergies: ____

Surgical History: ____

Please list imaging (X-ray, CT Scans, MRIs, etc.) or diagnostic tests (urodynamics, ultrasound, etc.) done in the past 6 months.

____

____

Please list ALL current medications, along with dosage and frequency.

Medications	Dosage	Frequency

Ob/Gyn History (females only)

Y/N Childbirth vaginal deliveries #____

Y/N Episiotomy #____

Y/N C-Section #_____

Y/N Difficult childbirth #_____

Y/N Prolapse or organ falling out

Y/N Vaginal dryness

Y/N Painful periods

Y/N Menopause – when? _____

Y/N Painful vaginal penetration

Y/N Pelvic pain

Y/N Other /describe____

What are your treatment goals? ____

I certify that all information provided is complete and accurate. No essential information has been omitted.

____

Patient/Guardian Signature Date

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PELVIC FLOOR 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 to you. 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 dysfunction. Pelvic floor dysfunctions include, but 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 rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength, and endurance, scar mobility and function of the pelvic floor region. I will have the opportunity to give/revoke my consent at each treatment session.

Treatment may include, but is not limited to the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching, 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, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my therapist.

POTENTIAL BENEFITS: May include an improvement in 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.

COOPERATION WITH TREATMENT: I understand that 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. 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.

- I understand my therapist will share with me her opinions regarding potential results of physical therapy 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 be treated. I hereby request and consent to the evaluation and treatment to be provided.

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Please initial below:

___________ I understand that I can terminate the procedure at any time.

___________ I have the option of having a second person present in the room during the procedure and **choose/refuse** (*please circle one*) this option.

Patient Name (please print): ____________________________________ **Date** _________________

Patient Signature____

If you are pregnant, have an infection of any kind, have vaginal dryness, are less than 6 weeks postpartum or post-surgery, have severe pelvic pain, sensitivity to lubricant, vaginal creams or latex, ***please inform the therapist prior to the pelvic floor assessment.*

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CONDITIONS OF ADMISSIONS

CAREFULLY READ ALL SECTIONS BELOW

AUTHORIZATION FOR TREATMENT

I hereby authorize and request treatment by the North River Therapy staff. My signature below indicates that I accept financial responsibility for all treatments and supplies not covered by insurance, which may consist of co-pays and deductibles. I also agree to pay all costs, expenses and attorney's fees incurred by North River Therapy or its authorized agent in collecting sums due. There is a $25 fee on all returned checks.

RELEASE OF INFORMATION

I do hereby request and authorize North River Therapy to obtain/disclose all or any part of my patient records to affiliated organizations of North River Therapy who are liable for all or any part of the patient's bill including but not limited to physicians, insurance companies, worker's compensation carriers or the patient's employer.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign and authorize direct payment to North River Therapy of all insurance benefits payable under the terms of any insurance policy for the services rendered. I remain responsible (unless otherwise provided by law) for any portion of the bill not paid by insurance.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO NORTH RIVER THERAPY

I request that payment of authorized Medicare benefits be made on my behalf for any services furnished by North River Therapy. I certify that the information given by me is correct. I authorize any holder of medical or any other information about me to release to North River Therapy any information needed to determine these benefits.

INSURANCE COVERAGE INFORMATION

I have been advised that while most insurance carriers cover outpatient therapy costs under the major-medical provisions in their policies, which in most cases require that the patient pay a deductible before the insurance company will begin paying benefits. After the patient pays the deductible, the remaining balance is then partially paid by the insurance company. This amount is usually 80% of the bill and the remaining 20% co-pay is the responsibility of the patient. Please be aware the amount and extent of said coverage varies from policy to policy and that your deductible and co-pays may be different from the above described. I realize that there may be unmet deductibles or co-payments due under the terms of my insurance policy and that I will be responsible for the payment of the same once services have been rendered. If you are not sure of your benefits, please contact your insurance company.

AUTOMOBILE ACCIDENTS

It is understood and agreed that it is my responsibility to pay out of pocket for any charges I may accrue while at North River Therapy. It is then my responsibility to coordinate my therapy bills with whomever is handling my automobile accident for possible reimbursement to me.

PERSONAL VALUABLES

It is understood and agreed that North River Therapy is not responsible for loss or damage to any personal valuables or properties.

I have read the above information and understood that I am responsible for any/all incurred amounts not covered by insurance.

____

Signature Date

NORTH RIVER
THERAPY

No Show/Cancellation Policy

Our goal at North River Therapy is to ensure that we return you to the best possible pain control and function. In order to do that, we need to see you on a regular basis.

We have made a commitment to give you the highest care possible, and your appointment time has been specifically reserved for you to serve your physical therapy needs. If you give us at least 24 hours' notice we usually can fill the appointment, but if we do not hear from you, no one can take your place.

So, in order to get you back to the things you love, and in order for us to keep our costs down, we have a policy that if you cancel OR "no show" 3 times in 30 days, you will be discharged. You can return after getting another referral from the doctor. Think of this as our commitment to get you better!

Please also be aware that North River Therapy will charge a **$45 fee for appointments not cancelled at least 24 hours before your appointment.** We will make exceptions for true emergencies, of course.

Should there be any time you do not cancel and do not come to your scheduled appointment without notifying our office, **you will be charged a No-Show fee of $75.** Please understand we do not charge this lightly; we simply must account for the time we have the therapists scheduled for your treatment.

Your insurance does not cover charges for late cancellations or no-shows, it is patient responsibility.

I have read and understand the cancellation policy. I recognize that my attendance and follow-through with therapy will directly affect my results.

___

Patient/Guardian Signature *Date*

___

Printed Name of Patient or Guardian *Date*