

PATIENT INFORMATION and FINANCIAL POLICY

Thank you for scheduling an appointment for Physical Therapy. My mission is to provide specialized physical therapy evaluation and one-on-one treatment in a practical and compassionate manner. After 25 years of practice, I started my own business to support my practice philosophy and allow me to continue national training of professionals interested in evaluation and treatment of the lumbopelvic girdle and pelvic floor muscle problems.

I have elected to no longer be a preferred provider for insurance companies. Instead, I provide physical therapy on a "fee at time of service" basis. By removing myself from a preferred provider/contracted status with the insurance companies, I do not have to limit the time or quality of treatment I provide because of insurance company restrictions or elevate my rates to pay for billing services. My extensive experience means that I can usually treat your problem with fewer appointments. What you are paying for is my skilled, devoted and professional expertise and time. Additionally, I have the flexibility to assist patients in financial need.

Prior to your first scheduled appointment, call your insurance company to completely understand your physical therapy benefits. There is an insurance benefits worksheet link posted on my website under Physical Therapy Practice and Fees, at the bottom of the page. When you call your insurance company, they will ask you for the name of the physical therapist you plan to see. At the time of service and payment, you will receive a written statement which you can submit to your insurance company for their consideration of reimbursement to you. I will be happy to provide chart notes or other documentation at your–or your insurance company’s–request. The amount of reimbursement you receive will vary according to the terms of your insurance policy. Some companies may reimburse you at 80%, some at 60%, some at 40%, and some may not reimburse you at all. I cannot make guarantees or estimates regarding what reimbursement your plan allows.

I accept cash, check or Visa/MasterCard at the time of service. My fees are based on time spent with you and the treatments performed during your appointment. The fee ranges are as follows:

\$165-205 for initial evaluation/treatment

\$150 for 50-55 minute appointments

\$112.50-\$75 for short appointments

\$75 for cancellations or missed appointments with less than 48 hours notice

I look forward to assisting and working with you.

Sincerely,

Kathe Wallace, PT, BCB-PMD

Patient History

Name _____ DOB _____ Age ___ Date _____

1. Describe the current problem that brought you here? _____

2. When did your problem first begin? _____

3. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date _____

4. Since that time is it: staying the _____ same _____ getting worse _____ getting better
Why or how? _____

5. If pain is present rate pain on a 0-10 scale 10 being the worst. _____

6. Describe the nature of the pain (i.e. constant burning, intermittent ache) _____

7. Describe previous treatment/exercises _____

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

- | | |
|--|--|
| <input type="checkbox"/> Sitting greater than _____ minutes | <input type="checkbox"/> With cough/sneeze/straining |
| <input type="checkbox"/> Walking greater than _____ minutes | <input type="checkbox"/> With laughing/yelling |
| <input type="checkbox"/> Standing greater than _____ minutes | <input type="checkbox"/> With lifting/bending |
| <input type="checkbox"/> Changing positions (ie. - sit to stand) | <input type="checkbox"/> With cold weather |
| <input type="checkbox"/> Light activity (light housework) | <input type="checkbox"/> With triggers i.e. /key in door |
| <input type="checkbox"/> Vigorous activity/exercise (run/weight lift/jump) | <input type="checkbox"/> With nervousness/anxiety |
| <input type="checkbox"/> Sexual activity | <input type="checkbox"/> No activity affects the problem |
| <input type="checkbox"/> Other, please list _____ | |

9. What relieves your symptoms? _____

10. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify _____
Diet /Fluid intake, specify _____
Physical activity, specify _____
Work, specify _____
Other _____

11. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst _____

12. What are your treatment goals/concerns? _____

Since the onset of your current symptoms have you had:

- | | | | |
|-----|--------------------------------------|-----|-------------------------------|
| Y/N | Fever/Chills | Y/N | Malaise (unexplained tirednes |
| Y/N | Unexplained weight change | Y/N | Unexplained muscle weakness |
| Y/N | Dizziness or fainting | Y/N | Night pain/sweats |
| Y/N | Change in bowel or bladder functions | Y/N | Numbness / Tingling |
| Y/N | Other /describe _____ | | |

Date of Last Physical Exam _____ Tests performed _____

Pg 2 History **Name** _____ **DOB ID#** _____ **Age** _____

General Health: Excellent Good Average Fair Poor Occupation _____

Hours/week _____ On disability or leave? _____ Activity Restrictions? _____

Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week

Describe _____

Mental Health: Current level of stress High_ Med__ Low__ Current psych therapy? Y/N

Have you ever had any of the following conditions or diagnoses? Circle all that apply

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple sclerosis	Allergies-list below
Ankle swelling	Head Injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/ Hyperthyroid
Low back pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug problem	Arthritic conditions	Kidney disease
Childhood bladder problems	Stress fracture	Irritable Bowel Syndrome
Depression	Acid Reflux /Belching	Hepatitis
Anorexia/bulimia	Joint Replacement	Sexually transmitted disease
Smoking history	Bone Fracture	Physical or Sexual abuse
Vision/eye problems	Sports Injuries	Raynaud's (cold hands and feet)
Hearing loss/problems	TMJ/ neck pain	Pelvic pain
Other/Describe _____		

Surgical /Procedure History

Y/N Surgery for your back/spine	Y/N	Surgery for your bladder/prostate
Y/N Surgery for your brain	Y/N	Surgery for your bones/joints
Y/N Surgery for your female organs	Y/N	Surgery for your abdominal organs
Other/describe _____		

Ob/Gyn History (females only)

Y/N Childbirth vaginal deliveries #_	Y/N	Vaginal dryness
Y/N Episiotomy #__	Y/N	Painful periods
Y/N C-Section #__	Y/N	Menopause - when? __
Y/N Difficult childbirth #__	Y/N	Painful vaginal penetration
Y/N Prolapse or organ falling out	Y/N	Pelvic/genital pain _____
Y/N Other /describe _____		

Males only

Y/N Prostate disorders	Y/N	Erectile dysfunction
Y/N Shy bladder	Y/N	Painful ejaculation
Y/N Pelvic/genital pain location _____		
Y/N Other /describe _____		

<u>Medications - pills, injection, patch</u>	<u>Start date</u>	<u>Reason for taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

<u>Over the counter -vitamins etc</u>	<u>Start date</u>	<u>Reason for taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Symptoms

- | | | | |
|-----|---------------------------------------|-----|--------------------------------------|
| Y/N | Trouble initiating urine stream | Y/N | Blood in stool/feces |
| Y/N | Urinary intermittent /slow stream | Y/N | Painful bowel movements (BM) |
| Y/N | Strain or push to empty bladder | Y/N | Trouble feeling bowel urge/fullness |
| Y/N | Difficulty stopping the urine stream | Y/N | Seepage/loss of BM without awareness |
| Y/N | Trouble emptying bladder completely | Y/N | Trouble controlling bowel urge |
| Y/N | Blood in urine | Y/N | Trouble holding back gas/feces |
| Y/N | Dribbling after urination | Y/N | Trouble emptying bowel completely |
| Y/N | Constant urine leakage | Y/N | Need to support/touch to complete BM |
| Y/N | Trouble feeling bladder urge/fullness | Y/N | Staining of underwear after BM |
| Y/N | Recurrent bladder infections | Y/N | Constipation/straining ____% of time |
| Y/N | Painful urination | Y/N | Current laxative use -type _____ |
| Y/N | Other/describe _____ | | |

Describe typical position for emptying: _____

1. Frequency of urination: awake hour's ____ times per day, sleep hours ____times per night
 2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? ____ minutes, __hours, _____not at all
 3. The usual amount of urine passed is: __small __ medium__ large
 4. Frequency of bowel movements ____ times per day, _____times per week, or _____.
 5. The bowel movements typically are: watery __ loose __ formed__ pellets __ other _____
 6. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? _____minutes, _____hours, _____not at all.
 7. If constipation is present describe management techniques _____
 8. Average fluid intake (one glass is 8 oz or one cup) _____ glasses per day.
Of this total how many glasses are caffeinated?____ glasses per day.
 9. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:
__None present
__Times per month (specify if related to activity or your menstrual period)
__With standing for _____ minutes or _____hours.
__With exertion or straining
__Other _____
-
- | | |
|--|---|
| <ol style="list-style-type: none"> 10a. Bladder leakage - number of episodes
__ No leakage
__ Times per day
__ Times per week
__ Times per month
__ Only with physical exertion/cough | <ol style="list-style-type: none"> 10b. Bowel leakage - number of episodes
__ No leakage
__ Times per day
__ Times per week
__ Times per month
__ Only with exertion/strong urge |
|--|---|
-
- | | |
|--|---|
| <ol style="list-style-type: none"> 11a. On average, how much urine do you leak?
__ No leakage
__ Just a few drops
__ Wets underwear
__ Wets outerwear
__ Wets the floor | <ol style="list-style-type: none"> 11b. How much stool do you lose?
__ No leakage
__ Stool staining
__ Small amount in underwear
__ Complete emptying
__ Other _____ |
|--|---|
-
12. What form of protection do you wear? (Please complete only one)
__None
__Minimal protection (tissue paper/paper towel/pantishields)
__Moderate protection (absorbent product, maxi pad)
__Maximum protection (specialty product/diaper)
__Other _____

On average, how many pad/protection changes are required in 24 hours? _____# of pads

CONDITIONS & CONSENT FOR PHYSICAL THERAPY

___ I understand that I am a patient of Kathe Wallace, PT who is an independent Physical Therapy practitioner practicing under Kathe Wallace Physical Therapy, PLLC, at 5901 Roosevelt Way NE Suite B, Seattle, WA 98105. This office is not a group practice, but rather a facility where independent practitioners share office space. My care is the exclusive responsibility of Kathe Wallace, PT not of any other practitioners who also practice at this location.

___ **Cooperation with treatment:**

I understand that in order for physical 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.

___ **Cancellation Policy**

I understand that if I cancel more than 48 hours in advance, I will not be charged. I understand that if I cancel less than 48 hours in advance or fail to come to a scheduled appointment, I will pay a cancellation fee of \$75.00.

___ **No warranty: I understand that Kathe Wallace Physical Therapy, PLLC and Kathe Wallace, PT cannot make any promises or guarantees regarding a cure for or improvement in my condition.** I understand that Kathe Wallace, PT will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Informed consent for treatment:

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

___ **Potential risks:** I understand 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 24 hours, I agree to contact my physical therapist.

___ **Potential benefits** may include 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 physicians/primary care provider or insurance company. Please list.

Financial and insurance responsibilities:

___ I agree to pay for my evaluation and treatments at the time of service, by cash, check, or charge card unless other mutually agreed upon arrangements have been made. I understand it is my responsibility to call my insurance company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of my benefits. I understand my therapist will provide me with a receipt that is my responsibility to submit to my insurance company.

I have read the above information and I consent to physical therapy evaluation and treatment. By initialing above and signing below, I acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

Print Name

Date

Patient's signature (if minor, parent or legal guardian must sign)

Therapist Signature / Date

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

Kathe Wallace Physical Therapy, PLLC
5901 Roosevelt Way NE, Suite B, Seattle, WA 98105

PLEDGE REGARDING MEDICAL INFORMATION

Washington State Law under the Uniform Health Care Information Act (Washington Rev. Code Ann. Section 70.02.005 et seq.) governs a patient's right of access to their healthcare information maintained by a healthcare provider. We are required by law to:

- Make sure that medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the notice that is currently in effect.

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your physicians or others working in this office.

Your Rights Regarding Health Information About You

- Right to Inspect and Copy.
- Right to Amend.
- Right to an Accounting of Disclosures.
- Right to Request Restrictions.
- Right to Request Confidential Communications.

A complete written notice is available and will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. You will be asked to acknowledge and sign a notice regarding HIPAA (the acronym for the Health Insurance Portability and Accountability Act) on your initial visit with Kathe Wallace, PT.