Metamora
Physical Therapy

3562 S. Lapeer Rd. Ste F, Metamora, MI 48455

Phone: 810-212-1277

1. CONSENT FOR TREATMENT: I consent to and authorize my physical therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.

2. APPOINTMENT ATTENDANCE AGREEMENT: I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of $50.

WORKER'S COMPENSATION PATIENTS: We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

3. RESPONSIBILITY FOR PAYMENT: All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by Metamora PT, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Metamora PT with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible. When you provide a check as payment in the clinic, you authorize us to use the information from your check to process a one-time Electronic Funds Transfer (EFT/ACH) or a draft drawn from your account, or to process the payment as a check transaction. When we use information from your check to make an EFT, funds may be withdrawn from your account as soon as the same day and you will not receive your check back from your financial institution.
Please note that refusal to sign this form does not change responsibility for payment in any way.

4. ASSIGNMENT OF BENEFITS: I hereby assign to Metamora PT all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

5. ACCESS TO AND RELEASE OF HEALTH INFORMATION: I understand that Metamora PT may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Metamora PT's administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Metamora PT's Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

6. HIPAA CONSENTS: In compliance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding the billing of my account:

Name/Relationship_____

Name/Relationship _____

Name/Relationship_____

I also authorize the release of appointment information left in a voice-mail, answering machine or text message and understand that there is some level of privacy risk associated with these forms of communication.

7. CONSENT FOR EMERGENCY CONTACT INFORMATION Person to contact in case of an emergency:

Name_____ Telephone Number_____ Relationship:_____

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

Signature of Patient or Legally Responsible Person_____ Date_____

Printed Name of above_____ Date _____

Metamora Physical Therapy complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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APPOINTMENT ATTENDANCE AGREEMENT

I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through to subsequent weeks. **I agree to provide at least 24 hours notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of $50.**

Name: _____

Signature: _____

Date: _____

Metamora Physical Therapy, LLC

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.

Metamora Physical Therapy, LLC's LEGAL DUTY

Metamora Physical Therapy, LLC is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Metamora Physical Therapy, LLC 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, Metamora Physical Therapy, LLC 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.

Metamora Physical Therapy, LLC may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Metamora Physical Therapy, LLC 's 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 future disclosures at any time.

Metamora Physical Therapy, LLC 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. Metamora Physical Therapy, LLC 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 Metamora Physical Therapy, LLC 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 US Department of Health and Human Services. For further information on Metamora Physical Therapy's health information practices or if you have a complaint, please contact the following person:

Metamora Physical Therapy, LLC
Office Administrator
3562 S. Lapeer Rd. Ste F, Metamora, MI 48455
Telephone: 810-212-1277 Fax: 810-212-1282

Metamora Physical Therapy, LLC
PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Metamora Physical Therapy, LLC's Notice of Information Practices. I understand that Metamora Physical Therapy, LLC 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 ABC PT/OT will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge to the use and disclosure of my personal health information for purposes as noted in Metamora Physical Therapy, LLC's Notice of Information practices. I understand that I retain the right to revoke this acknowledgement by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date

I also authorize Metamora Physical Therapy, LLC 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

_____
Signature

_____
Date

PATIENT NAME	**DATE:**
ADDRESS:	**DOB:**
CITY/ZIP:	**CELL#**
DOCTOR:	**EMAIL:**
ARE YOU CURRENTLY WORKING OUTSIDE THE HOME?	**OCCUPATION:**

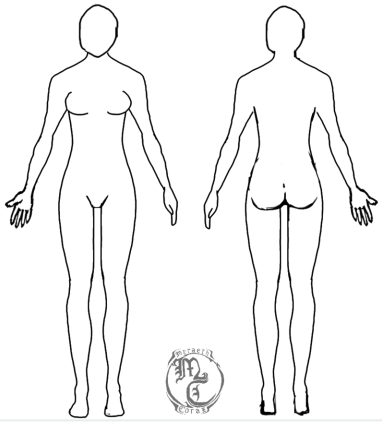
PLEASE DESCRIBE YOUR SYMPTOMS THAT BRINGS YOU TO HEAR TODAY:

WHEN DID THESE SYMPTOMS START?_____

WHAT MAKES YOUR SYMPTOMS BETTER?_____

WHAT MAKES YOUR SYMPTOMS WORSE?_____

PLEASE MARK THE AREAS THAT BOTHERING YOU:



PLEASE RATE YOU PAINO NO PAIN AND 10 WOST.

0 1 2 3 4 5 6 7 8 9 10

PLEASE DESCRIBE YOUR PAIN (SHARP/DULL/BURNING/THROBBING, ECT)

WHAT ARE YOUR GOALS FOR THERAPY?

PELVIC FLOOR MEDICAL HISTORY:

DO YOU HAVE A MEDICAL DIAGNOSIS (IE PROLAPSE, INCONTINENCE, IC……)
HAVE YOU HAD ANY TREATMENT FOR THIS DIAGNOSIS?
HAVE YOU HAD ANY SPECIAL TESTS COMPLETED RELATED TO THIS DIAGNOSIS?

GENERAL HEALTH HISTORY: PLEASE CIRCL ANY OF THE FOLLOWING THAT APPLY TO YOU

ADHD	**TMJ**	**ALLEGIES**	**CONSTIPATION/DIARREHA**
ANEMIA	**DIABETES**	**ANXIETY/DEPRESSION**	**DIGESTIVE PROBLEMS**
ARTHRITIS:	**DIZZINESS/VERTIGO**	**ASTHMA**	**EATIING DISORDER**
COPD	**MENTAL HEALTH ISSUES**	**FIBROMYALGIA**	**BLADDER ISSUES**
HEADACHE/MIGRANES	**CANCER**	**LEARNING DISABILITIES**	**CARDIOVASCULAR**
HIGH BLOOD PRESSURE	**NEUROLOGICAL PROBLEMS STROKE/MS/PARKINSONS**	**CHRONIC FATIGUE**	**OSTEOPEROSIS**
CHRONIC PAIN	**SEIZURES**	**SLEEP DISORDER**	

PLEASE LIST ANY SURGERIES YOU HAVE HAD AND DATES OF THE SURGERY:
PLEASE LIST ANY SIGNIFICANT INJURIES (ACCIDENTS, FRACTURES) AND DATE OF OCCURRENCE:
ANY COMPLICATIONS WITH CHILDBEARING/BIRTHING PROCESS/BREASTFEEDING?

FEMALE HISTORY:

# OF PREGNANCIES	**# OF BIRTHS**	**# OF VAGINAL BIRTHS**	**# OF C-SECTIONS**
ENDOMETRIOSIS: Y/N	**INTERSISTIAL CYSTITIS: Y/N**	**EPISIOTOMY: Y/N**	**PROLAPSE: Y/N**

DRYNESS: Y/N	**PAINFUL MENSTURAL CYCLE: Y/N**	**MENSTURAL CYCLE; LIGHT/REGULAR/HEAVY/ PAIN**	**MENOPAUSE: Y/N**

DO YOU EXPERIENCE STRESS? NONE/ LOW/ MEDIUM/ HIGH
WHAT DO YOU DO TO REDUCE STRESS?
DO YOU EXERCISE? Y/N. IF YES WHAT AND HOW OFTEN:
HOW MANY HOURS OF SLEEP DO YOU GET A NIGHT.? ANY DIFFICULTY FALLING ASLEEP? Y/N
HOW MANY HOURS OF SCREEN TIME A DAY?
HOW WOULD YOU DESCRIBE YOUR DIET? POOR/GOOD/BAD? FRUITS/VEGETABLES?
HOW MANY CAFFINATED BEVERAGES PER DAY? HOW MUCH WATER PER DAY?
ANY HISTORY OF TRAUMA (SEXUAL OR PHYSICAL)? Y/N

HOW WILLING ARE YOU TO COMMIT TO CHANGING IN ORDER TO GET RID OF YOUR SYMPTOMS? **WHATEVER IT TAKES/ SIGNIFICANT CHANGE/ SOME CHANGE/ NO CHANGE**
DO YOU HAVE A SAFE SUPPORT SYSTEM.? Y/N
IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW?

PATIENT SIGNATURE _____ **DATE** _____

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How many times do you urinate in the day?	Up to 7	Between 8-10	Beween 11-15	More than 15
How many times do you get up at night to urinate	0-1	2 times	3 times	More than 3 times
Do you wet the bed before you wake up at night?	Never	Occasionally-less than once per week	Frequently-once or more per week	Always-every night
Do you rush or hurry to urinate when you get the urge?	Never- can hold on	Occasionally-less than once per week	Frequently-once or more per week	Daily
Do you leak when rush or hurry to the toilet?	Never	Occasionally-less than once per week	Frequently-once or more per week	Daily
Do you leak with squatting, sneezing, laughing or coughing?	Never	Occasionally-less than once per week	Frequently-once or more per week	Daily
Is your urinary stream weak, prolonged or slow?	Never	Occasionally-less than once per week	Frequently-once or more per week	Daily
Do you ever have a feeling of incomplete bladder emptying?	Never	Occasionally-less than once per week	Frequently-once or more per week	Daily
Do you need to strain to empty your bladder?	Never	Occasionally-less than once per week	Frequently-once or more per week	Daily
Do you have to wear pads because of urinary leakage?	None-never	As a precaution	With exercise	Daily
Do you limit your fluid intake to decrease leakage?	Never	Before going out	Moderately	Daily
Do you have frequent bladder infections?	No	1-3 per year	4-12 per year	More than once per month
Do your have pain when you empty your bladder?	Never	Occasionally-less than once per week	Frequently-once or more per week	Daily
Doe leakage affect your daily routine?	Not at all	Slightly	Moderately	Greatly

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How often do you usually have a bowel movement?	Every other day	Less than every 3 days	Less than once a week	More than once a day
What is the consistency of your stool?	Soft	Had/pebbles	Watery	Firm
Do you have to strain a lot to empty your bowels?	Never	Occasionally-less than once per week	Frequently- more than once per week	Daily
Do you use laxatives?	Never	Occasionally-less than once per week	Frequently- more than once per week	Daily
Do you feel constipated	Never	Occasionally-less than once per week	Frequently- more than once per week	Daily
Do you get gas you can't control?	Never	Occasionally-less than once per week	Frequently- more than once per week	Daily
Do you have urgency to empty your bowels?	Never	Occasionally-less than once per week	Frequently- more than once per week	Daily
Do you leak watery stool?	Never	Occasionally-less than once per week	Frequently- more than once per week	Daily
Do you leak normal stool?	Never	Occasionally-less than once per week	Frequently- more than once per week	Daily
Do you have a feeling of incomplete bowel emptying?	Never	Occasionally-less than once per week	Frequently- more than once per week	Daily

Do you have a sensation of tissue protrusion, lump, or bulging in you vagina?	Never	Occasionally-less than once per wee	Frequently-more than once per week	Daily
Do you experience vaginal pressure, heaviness or a dragging sensation?	Never	Occasionally-less than once per wee	Frequently-more than once per week	Daily
Do you have to push on your perineum to empty your bowels	Never	Occasionally-less than once per wee	Frequently-more than once per week	Daily
Do you have to push on your perineum to void?	Never	Occasionally-less than once per wee	Frequently-more than once per week	Daily
How much of bother are these symptoms	Not at all	Slightly	Moderately	Greatly

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Are you sexually Active?	No	Less than 1x week	More than 1x week	Daily or most days
If not sexually active, why:	No partner	Partner unable	Vaginal Dryness	Too Painful
Do you have sufficient vaginal lubrication during intercourse?	yes	No		
During intercourse, is vaginal sensation?	Normal	Decreased	Painful	None
Do you feel your vagina is too loose?	Never	Occasionally	Frequently	Always
Do you feel your vagina is too tight?	Never	Occasionally	Frequently	Always
Do you have pain with intercourse?	Never	Occasionally	Frequently	Always
	If pain, where does it occur?	Deep inside	Upon insertion	Both insertional and deep inside
Do you leak urine during intercourse?	Never	Occasionally	Frequently	Always
How much do these sexual issues bother you?	Not at all	Slightly	Moderately	Greatly

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PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are 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 and 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/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, car mobility and function of the pelvic floor region.

Treatment may include, but 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 and strengthening exercises, soft tissue nd/or joint mobilization and educational instruction.

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 a an 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.

The purpose, risks and benefits of this evaluation have been explained to me

- ☐ I understand that I can terminate the procedure at any time.
- ☐ I understand that I am responsible fo immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation.
- ☐ I understand I have the option too having a second person in the room during the procedure and will inform my therapist my wishes.
- ☐ give my informed consent for pelvic floor examination and treatment

_____. _____

Printed name of Patient DOB

_____ _____

Signature of Patient/Parent/Guardian Date of signing

_____

Printed name of parent/guardian if applicable