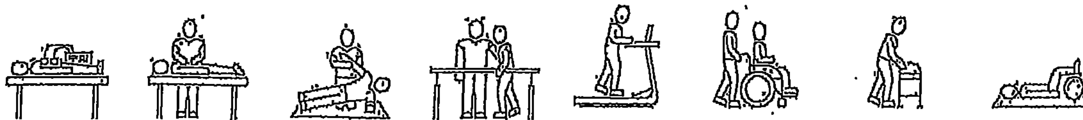
Thank you for choosing Advanced Care Physical Therapy



You have an appointment for an evaluation in our office on ____________________ at ________am/pm. To assist us in treating you properly, please fill out this packet of information. Be sure to bring this paperwork completed, along with the prescription from your doctor to our office, photo ID, and insurance cards. *Please arrive 20 minutes prior to your appointment time.* Allow yourself at least an hour for the initial evaluation.

Come prepared with comfortable clothing and appropriate shoe wear for the gym. Be sure to bring adequate swimming attire and a towel if your therapy involves the pool. If you are being treated for your legs or any lower extremity, please bring a pair of shorts.

Please call the office if for any reason your initial evaluation appointment needs to be rescheduled. Unless the initial evaluation is re-scheduled, all of your following scheduled appointments will be cancelled.

Please give 24-hour notice for any cancellations

Patients should obtain a prescription from a physician for a specific area of injury and use it within 30 days..

Directions to Office

North of office: Beltway 695 exit 31 south. Go down to the 3rd light and make a left on Linwood Ave. Make an immediate left into our back parking lot.

South of office: We are located one block north of Taylor Ave. Make a right on to Linwood Ave. Make an immediate left into our back parking lot.

Make sure you enter through the back for our FREE parking

8005 Harford Road, Suite 102, Parkville, MD 21234 ▲ Phone: 410.663.3133 ▲ Fax: 410.663.3089

Pre-screening Health Questions related to COVID-19

******If the answer to any question below is "yes," please explain which household member(s) are affected and provide as much detail as possible.*

1. In the past 14 days, has anyone in the household been potentially exposed to COVID-19 (close contact with someone who has recently traveled, been diagnosed with the virus and/or shown symptoms, or working in the medical field)?

   ☐Yes ☐ No ☐ Unknown

2. Does anyone in the household have a cough or shortness of breath or difficulty breathing; or at least two of the following symptoms: fever, chills, repeated shaking with chills, muscle pain, headache, sore throat or new loss of taste or smell; and the symptoms could be related to potential exposure to COVID-19?

   ☐ Yes ☐ No ☐ Unknown

3. Has anyone in the household tested positive for COVID-19 in the past 14 days?

   ☐ Yes ☐ No ☐ Unknown

4. Is anyone in the household isolated/quarantined per doctor's orders?

   ☐ Yes ☐ No ☐ Unknown

Pelvic Floor Disability Index (PFDI-20)

Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, **how much they bother you**. Answer these by circling the appropriate number. While answering these questions, please consider your symptoms over the last 3 months. The PFDI-20 has 20 items and 3 scales of your symptoms. All items use the following format with a response scale from 0 to 4.

Symptom scale:
0 = not present
1= not at all
2 = somewhat
3 = moderately
4 = quite a bit

Pelvic Organ prolapse Distress Inventory 6 (POPDI-6)

Do You...	**NO**	**YES**
1. Usually experience pressure in the lower abdomen?	0	1 2 3 4
2. Usually experience heaviness or dullness in the pelvic area?	0	1 2 3 4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1 2 3 4
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1 2 3 4
5. Usually experience a feeling of incomplete bladder emptying?	0	1 2 3 4
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1 2 3 4

Colorectal-Anal distress Inventory 8 (CRAD-8)

Do You...	**NO**	**YES**
7. Feel you need to strain too hard to have a bowel movement?	0	1 2 3 4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1 2 3 4
9. Usually lose stool beyond your control if your stool is well formed?	0	1 2 3 4
10. Usually lose stool beyond your control if your stool is loose?	0	1 2 3 4
11. Usually lose gas from the rectum beyond your control?	0	1 2 3 4
12. Usually have pain when you pass your stool?	0	1 2 3 4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1 2 3 4
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1 2 3 4

Urinary distress Inventory 6 (UDI-6)

Do You...	**NO**	**YES**
15. Usually experience frequent urination?	0	1 2 3 4
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	0	1 2 3 4
17. Usually experience urine leakage related to coughing, sneezing or laughing?	0	1 2 3 4
18. Usually experience small amounts of urine leakage (that is, drops)?	0	1 2 3 4
19. Usually experience difficulty emptying your bladder?	0	1 2 3 4
20. Usually experience pain or discomfort in the lower abdomen or genital region?	0	1 2 3 4

Scoring the PFDI-20
Scale Scores: Obtain the mean value of all of the answered items within the corresponding scale (possible value 0 to 4) and then multiply by 25 to obtain the scale score (range 0 to 100). Missing items are dealt with by using the mean from answered items only.

Pelvic Dysfunction Intake Form

Preferred Name: ______________________ Legal Full Name: ________________________________

Pronouns: __________________________

Are you having difficulties completing this form? Yes/No

If yes, see front desk staff for assistance

Who is your Primary Care Physician (PCP)? ________________________________

Living Environment – Does your home have:

___ Stairs with Railing ___ Stairs without Railing ___ Ramps ___ Uneven Terrain ___Elevator

Obstacles: ____

Assistive Devices (including raised commodes): ____

With Whom do you Live? ____ Alone ___Spouse ___Partner ___Children ___Parents ___Other

Gender Identity: ____

Sex Assigned at Birth: ___Female ___Male ___Intersex ___Decline to State

How did you hear about us? ____

Employment/Work Occupation:

____

___Working Full Time ___Working Part Time ___Homemaker ___Student ___Retired ___Disabled ___Unemployed

Health Habits Smoking Currently: ___Yes ___No

Alcohol Intake: ___Current ___Past ___Never

Do you exercise beyond normal daily activities and chores? ___Yes ___No

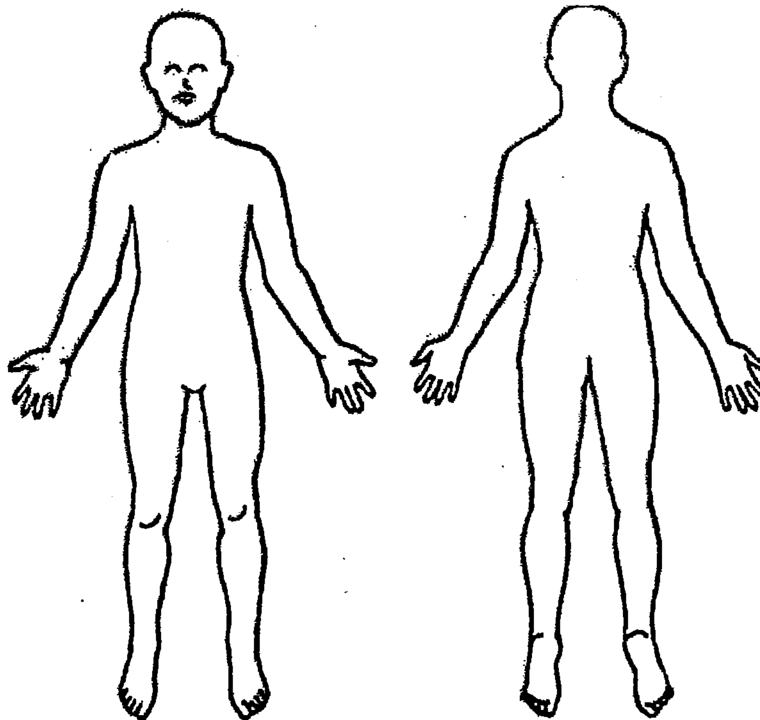
If yes, what exercise(s) do you perform? ____

Please describe your main problem or reason for your visit today _____________________________________

____

When did it begin? ______________________________ Is it getting: ___Better ___Worse ___Staying the Same

On the diagram below, please indicate & label where your current pain or problem is located:



Have you ever had this problem before? ___Yes ___No

If yes: Did it get better? ___Yes ___No

How long did the problem last? ____

What did you do for the problem? ____

How are you taking care of this problem now? ____

What are your goal(s) for therapy? ____

____

Do you have any concerns about your personal safety? ___Yes ___No ___Prefer not to answer

Do you have a history of trauma of which you would like your therapist to be aware? _______________

____

Pain - Do you experience an increase in your pain with any of the following:

During, starting or after sexual intercourse? YES NO

If yes, does the pain occur with initial entry, deep thrust or both?

Please explain if necessary: ___________________________________

Certain postures (i.e. sitting, standing, stooped etc...) or positions? YES NO

If yes, explain ___________________________________

At a certain time of the day? YES NO

If yes, explain ___________________________________

With a specific activity or exercise? YES NO

If yes, explain ___________________________________

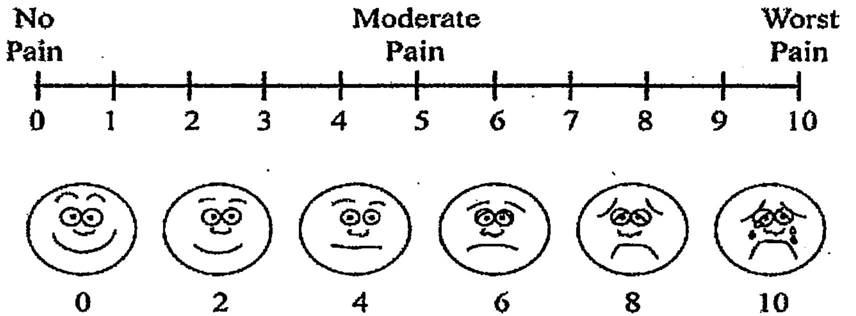
What do you do to alleviate your pains? ___________________________________

Please mark which number and/or face best describe your current condition:

Current Pain: 0 1 2 3 4 5 6 7 8 9 10

Lowest Pain: 0 1 2 3 4 5 6 7 8 9 10

Worst Pain: 0 1 2 3 4 5 6 7 8 9 10



Have you had to restrict or change any of the following because of pain?

- ❑ Exercise
- ❑ Wearing tight pants or jeans
- ❑ Sitting or sitting on hard surfaces
- ❑ Sexual or social relationships
- ❑ Use of tampons
- ❑ Work

Are you Sexually Active? **YES** **NO**

If yes, please circle which (if any) apply to your current condition (Marinoff Scale)

0 : No pain or difficulty with intercourse

1 : Causes discomfort but does not interfere with frequency of intercourse

2 : Sometimes prevents intercourse

3 : Completely prevents intercourse

Reproductive Medical History

Number of pregnancies: _____ Number of vaginal births: _____ Number of C-Section or assisted births: _____

Weight of largest baby at birth: _______________ Are you currently breastfeeding or pregnant? YES NO

Any pregnancy/delivery complications, vaginal tearing or episotomies? YES NO

If yes, explain ___________________________________

Did you have any back, hip, pelvic or other pains during pregnancy or in the post-partum period? YES NO

If yes, explain ___________________________________

Are you currently pregnant, using birth control or hormone replacement therapy? YES NO

If yes, explain ___________________________________

Have you had any surgeries of your reproductive organs, pelvic floor or abdomen? YES NO

If yes, explain ___________________________________

General Medical History

Do you experience frequent urinary or yeast infections? YES NO

Do you experience any itching or burning sensations? YES NO

If yes, where? ____

Have you ever had a feeling of heaviness, pressure, falling out or told you have pelvic organ prolapse before? YES NO

If yes, please indicate occurrence of symptoms: (check all that apply)

- ❑ Never
- ❑ Pressure all day
- ❑ Pressure during menses
- ❑ Pressure increasing throughout the day
- ❑ Pressure with standing
- ❑ Pressure with straining

Have you ever been taught or told to do pelvic floor exercises/Kegels before? YES NO

Do you perform Kegels on a regular basis? YES NO If so, when? ________________________

Any other surgeries or conditions that might affect your current condition? YES NO

If yes, explain ____

Urinary and Bowel Habits

Do you experience constipation or diarrhea? YES NO (if yes, please circle which)

Do you have difficulty holding back gas? YES NO

Do have difficulty starting when you go to the bathroom? YES NO

Do you have difficulty completely emptying your bladder? YES NO

How many times do you go to the bathroom during the day? _______ during the night? _______

If experiencing leakage of urine or stool, is this occurring:

- ❑ Never
- ❑ Less than 1x/month
- ❑ 1x/week
- ❑ More than 1x/week
- ❑ Daily with ____ leaks/day

Are you using protection for leakage?

- ❑ No protection
- ❑ Shields/Liner
- ❑ Light Pad
- ❑ Moderate Pad
- ❑ Heavy Pad
- ❑ Adult Diaper
- ❑ ________ number of pads/day

How long can you delay the urge to urinate without leakage? ____________________

Frequency of Daytime Urination:

- ❑ 1-4 voids
- ❑ 5-8 voids
- ❑ 9-12 voids
- ❑ 13+ voids

Are you waking at night to urinate? __Yes __No

If yes, indicate how many times/night, on average: _________ times

Do you have any difficulty initiating urination? __Yes __No

Frequency of Bowel Movements:

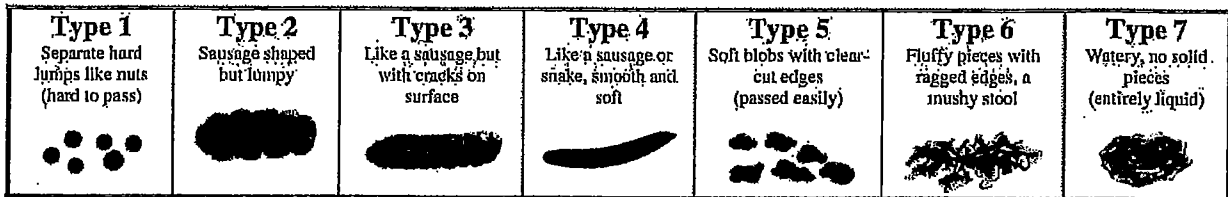
- ❑ 3+ times/day
- ❑ 1-2 times/day
- ❑ Every other day
- ❑ ________ times/week

Do you have difficulty passing bowel movements? __Yes __No

Do you experience any leakage of urine or feeling of urgency during any of the following:

- ❑ Coughing, laughing or sneezing
- ❑ Exercising or running
- ❑ On the way to the bathroom
- ❑ Immediately after using the bathroom
- ❑ With running water
- ❑ With sexual intercourse
- ❑ When pregnant or post-partum
- ❑ As a child (including bed wetting)

Bristol Stool Chart- please circle the type of stool you most commonly experience:



Clinical Tests Performed for this Condition (check all that apply):

- ❑ X-Ray
- ❑ MRI
- ❑ CT scan
- ❑ Endoscopy
- ❑ Anorectal Manometry
- ❑ Cystoscopy
- ❑ Colonoscopy
- ❑ Barium Enema
- ❑ Defecography
- ❑ Hysteroscopy
- ❑ Urodynamic Testing
- ❑ Ultrasound
- ❑ Colorectal Transit Study
- ❑ Q-tip test
- ❑ Biopsy
- ❑ Laparoscopy
- ❑ Nerve Conduction Velocity (NCV)
- ❑ Pelvic Exam

Other:____

Is there anything this form did not ask, but you would like to share with your therapist so they can help you better?

____

____

INFORMED CONSENT FOR PELVIC FLOOR MUSCLE EVALUATION

During the physical therapy evaluation for the problems you have reported, an assessment of your low back, hips, and pelvic girdle will be performed by a physical therapist in order to identify any musculoskeletal problems. This may include an evaluation of your pelvic floor muscles for strength, resting tone (tightness), and coordination (contract/relax). The findings will be discussed with you, and you will work with your physical therapist to develop a treatment plan that is appropriate for YOU. Your evaluation MAY include an internal assessment of the pelvic floor muscles, which could be completed vaginally (females) or rectally (males & females). A biofeedback assessment of your pelvic floor muscles may also be performed and may include internal or external sensors. Your physical therapist will discuss this option and receive your consent BEFORE initiating this exam. You absolutely can say NO, and your physical therapist can assess and treat the pelvic floor muscles externally (from the outside) if needed. The assessment of the pelvic floor muscles may result in soreness or discomfort temporarily. If this occurs, please discuss your symptoms with your physical therapist.

We realize that many patients may be apprehensive because of the private nature of the condition and the examination. Please ask as many questions as you need to increase your comfort and understanding of your evaluation, its findings, and treatment. Please discuss any concerns or hesitation that you may have with your physical therapist.

By signing this form, you agree and understand that treatment as indicated above may be necessary for effective treatment of your problem, and you agree that we have your permission to treat as discussed. You are always free to change your mind at any time during your course of treatment, and you are encouraged to notify your physical therapist of any changes of your preferences.

If you consent, you have the option to have a second person in the room for the pelvic floor muscle evaluation and treatment (as described above). The second person could be a friend, family member, or clinic staff member. Please indicate your preference with your initials:

________ **YES** I want a second person present during the pelvic floor muscle evaluation and treatment.

________ **NO** I do not want a second person during the pelvic floor muscle evaluation and treatment.

________ I would like to discuss my options with my physical therapist prior to consenting.

CONSENT

I have read and understand the Informed Consent for Pelvic Floor Muscle Evaluation, and I consent to the evaluation and treatment, unless otherwise noted below.

____

(Please list any exception to consent – if none, write none.)

Signature: ____ **Date:** ______________

Advanced Care Physical Therapy, Inc.
8005 Harford Road
Suite 102
Parkville, MD 21234
410-663-3133

Dear Patient,
In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT.

We now offer the following payment options:

__Payment By Cash
__Payment By Check
__Payment By Credit Card
__Automatic Monthly Billing To Your Credit Card
__Guarantee Any Amount Not Covered By Insurance With Your Credit Card

Please make your choice, sign below and return to the office before treatment.

Our office is a fully approved and an accredited user of the Visa and Master Card Health Care Program which will enable you to use your Visa or Master Card to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your credit card on a monthly basis.
If none of the above apply, please see the practice manager, Thank you.

Print your name here and sign below:

X_______________________________

X_______________________________ Date: ___________________________

Advanced Care Physical Therapy, Inc.
8005 Harford Road Suite 102
Parkville, MD 21234
410-663-3133

Patient Name: ________________________________ Date:_________________

I hereby instruct and direct ____________________________ Insurance Company to pay by check made out to:

Advanced Care Physical Therapy, Inc.
8005 Harford Road Suite 102
Parkville, MD 21234

If my current policy prohibits direct payment to doctors, I hereby also instruct and direct you to make out the check to me and mail it as follows:

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in a current manner, any balance of said professional services charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any physician, insurance company, adjuster or attorney involved in this case.

I authorize the doctor to initiate a complaint to the insurance Commissioner for any reason on my behalf.

______________________________ ______________________________

Signature of Policyholder Witness

Advanced Care Physical Therapy, Inc.

NOTICE OF PATIENT INFORMATION PRACTICES

Advanced Care Physical Therapy 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 here.

USES AND DISCLOSURES OF HEALTH INFORMATION

Advanced Care Physical Therapy 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.
Advanced Care Physical Therapy 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, Advanced Care Physical Therapy'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.

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 your treatment, payment or other related administrative purposes.

For further information on Advanced Care Physical Therapy health information practices, please contact the following person:

Advanced Care Physical Therapy, Inc.
Candice Bonner, Practice Manager
8005 Harford Road Suite 102
Parkville, MD 21234
Telephone: (410) 663-3133 Fax: (410) 663-3089

ADVANCED CARE PHYSICAL THERAPY, INC.

Patient Information Consent Form

I have read and fully understand Advanced Care Physical Therapy's Notice of Information Practice. I understand that Advanced Care Physical Therapy may use or disclose my personal health information for the purposes of caring out treatment, obtaining the payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

Patient Name: ____

Signature: ____________________________ Date: ______________

ADVANCED CARE PHYSICAL THERAPY'S NON-SOCIALIZATION POLICY:

Employees and personnel of Advanced Care Physical Therapy, Inc. are Professionals and are not permitted to socialize with or accept social invitations and/or requests from patients.

1. As a patient of Advanced Care Physical Therapy, Inc. I have been made aware of and agree to abide by Advanced Care Physical Therapy, Inc.'s above stated Non-Socialization Policy.
2. I understand and agree that as a patient of Advanced Care Physical Therapy, Inc., I am not permitted to extend social invitations and/or requests to Employee's and/or Personnel of Advanced Care Physical Therapy Inc.
3. I understand and agree that if, in Advanced Care Physical Therapy's sole discretion, I violate the aforesaid Non-Socialization Policy, Advanced Care Physical Therapy, Inc. shall be entitled to discontinue treating me as a patient and I hereby agree to accept such termination.

I have read, and understood, and signed this Policy acknowledgement on the date below.

Patient Signature: ______________________________ Date: ____________