61 Thomas Johnson Drive
Frederick, Maryland 21702

Phone: (301) 698-9214
Fax: 1-800-881-9610
Email: marci@3wpt.com

PATIENT REGISTRATION FORM

First Name: _____ Last Name: _____M.I: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____ E-mail Address: _____

Birth Date: _____ Age: _____ Occupation:_____ Marital Status: _____

Primary Phone: _____ Please indicate *(circle one)*: Home Work Cell

Secondary Phone: _____ Please indicate *(circle one)*: Home Work Cell

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____ Please indicate *(circle one)*: Home Work Cell

Primary Care Physician: _____ City, State: _____

Referring Physician: _____ City, State: _____

If the patient is not the insured or is a minor, the patient or parent should provide the information below:

Insured's Name: _____ Relation to Patient: _____

Insured's DOB: _____

How did you hear about our office? *(Please check all that apply)*

- ☐ **Physician Referral**
- ☐ **Friend/Family**
- ☐ **Brochure**
- ☐ **Internet Search**
- ☐ **Other: _____**

Is this a Worker's Compensation Case? Yes No
If yes, has this claim been accepted? Yes No Pending
Is this a motor vehicle related injury? Yes No

If you answered YES to A or B above, please provide the following information:

Insurance Co. Name & Address: _____

_____

Claim #: _____

Adjustor's Name: _____ Phone Number: _____

I CERTIFY that the information I have given above is correct and I authorize the release of any necessary information to my insurance company. I permit a copy of this authorization to be used in place of the original and I authorize this signature to be used when processing claims.

Patient Name *(Please Print)*: _____ **Date:** _____

Patient Signature: _____

Signature of Parent or Guardian *(If applicable)*: _____

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HIPPA PRIVACY FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As my patient I want you to know that I respect the privacy of your personal medical information and will do all I can to secure and protect that privacy. When it is appropriate and necessary, I provide the minimum necessary information to only those I feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. I may need to contact your primary care physician, referring physician and/or specialist to discuss your medical condition or request information. If test(s) have been administered I may need to request test results. I also want you to know that I support your full access to your personal medical records.

You may refuse to consent to the use or discloser of your personal health information, but this must be in writing. Under this law, I have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

COMMUNICATION AUTHORIZATION

☐ **Yes, you may leave a voicemail message at the following contact phone numbers *(please check all that apply)*:**
- o **Home**
- o **Work**
- o **Cell**

☐ **Yes, you may e-mail me at _____. I understand e-mail is NOT considered a private/secure method of communication.**

☐ **Yes, I would like to receive appointment reminders via *(please check all that apply)*:**
- o **Text or SMS**
- o **Email**

☐ **No, please <u>do not</u> contact me by the following means:**
_____.

I understand that I may authorize Provider to share medical/billing information about my care to relatives, caretakers, close friends, etc., and shall list them below:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

******This authorization shall expire upon written request or in the case of a minor having reached the age of majority.******

Patient Name *(Please Print)*: _____ **Date:** _____

Patient Signature: _____

Signature of Parent or Guardian *(If applicable)*: _____

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CONDITIONS & CONSENT FOR TREATMENT

I understand that I am a patient of Marshall Physical Therapy DBA Women's Wellness Works which is an independent Physical Therapy practice. My care is the exclusive responsibility of Marci Marshall, PT, PRPC.

Informed Consent for Treatment:

- **The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy 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 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 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, 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/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.**
- **Your physical therapist is female. No chaperone will be provided during your physical therapy evaluation and treatment sessions unless you request a chaperone to be present. You may choose to bring a friend or family member during the physical therapy evaluation or treatment at any time.**
- **Treatment may include, but not be limited to the following: observation, palpation, use of vaginal weights, dilators, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.**
- **I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.**
- **I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.**

Conditions for Treatment:

- **In order to successfully achieve the goals of treatment established by you and the healthcare professional; consistent, prompt attendance and compliance with the home program according to your plan of care is essential. If you repeatedly cancel or miss appointments, the healthcare professional will not be able to successfully help you meet your goals.**
- **If you cancel more than 24 hours in advance, you will not be charged. If you cancel less than 24 hours in advance, a cancellation fee of $50.00 will be charged. Extenuating circumstances shall be considered in waiving the cancellation fee at the discretion of the healthcare professional.**
- **Please have all family members and friends, unless a part of therapy, wait in the lobby. An adult must supervise children under 10 years-old, who are waiting in the lobby.**

Patient Name *(Please Print)*: _____ **Date:** _____

Patient Signature: _____

Signature of Parent or Guardian *(If applicable)*: _____

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FINANCIAL AND INSURANCE RESPONSIBILITIES

- **Deductibles, co-payments or coinsurances are collected at the time services are rendered.**
- **Deductibles: If you have a large deductible that has not yet been met, you will pay $100.00 per visit up front until you receive your Explanation of Benefits (EOB) from your insurance company. Once your EOB has been sent and the exact amount due is learned you will be responsible for the remainder of your deductible (if any) at that time. If you have overpaid on your deductible, you will be reimbursed within 7 to 14 days of MPT receiving your EOB from your insurance company.**
- **Patients are responsible for all deductibles; co-payments or co-insurances; and charges "not covered" by health insurance.**
- **I agree to obtain managed care referrals as needed.**
- **I request that payment of authorized Medicare, Medicaid and/or other benefits be made on my behalf to Marshall Physical Therapy. I authorize Marshall Physical Therapy, if it chooses, to pursue on my behalf any appeals of the denial of my insurance benefits, and to release my medical records as required to determine benefits payable. Marshall Physical Therapy, its agents and employees are hereby released from any and all liability of any nature that may arise from the release of information.**
- **I also understand that all insurance coverage estimates quoted to me and/or other responsible party is estimated, and that I and/or other responsible party shall be liable for all charges not covered by insurance whether or not such coverage agrees with the amount estimated. I certify that I have disclosed any and all health insurance coverage information.**
- **It is my responsibility to understand both my "in-network" and "out-of-network" benefits and that I may be responsible for additional payments at a future date. (This could occur after completion of processing initial claims).**
- **I guarantee the payment of the full and entire amount of all bills rendered for the patient. Any amount not paid within ninety (90) days of any notice of non-payment shall be subject to an interest charge of 1.5% per month on the unpaid balance, reasonable collection fees and/or attorney fees, and court costs. Payment plans may be arranged at the discretion of MPT.**

I (the client of Women's Wellness Works) have read and understand the office policies explained above:

Patient Name *(Please Print)*: _____ **Date:** _____

Patient Signature: _____

Signature of Parent or Guardian *(If applicable)*: _____

OFFICE USE ONLY – DO NOT SIGN:

Therapist who reviewed financial policy with this client: (Print Name): _____

Signature: _____ Date: _____

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MEDICAL HISTORY

Existing or Relevant Previous Conditions

Allergies	◯ Yes	◯ No	**Dizzy Spells**	◯ Yes	◯ No	**MRSA**	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	**Emphysema/Bronchitis**	◯ Yes	◯ No	**Multiple Sclerosis**	◯ Yes	◯ No
Anxiety	◯ Yes	◯ No	**Fibromyalgia**	◯ Yes	◯ No	**Muscular Disease**	◯ Yes	◯ No
Arthritis	◯ Yes	◯ No	**Fractures**	◯ Yes	◯ No	**Osteoporosis**	◯ Yes	◯ No
Asthma	◯ Yes	◯ No	**Gallbladder Problems**	◯ Yes	◯ No	**Parkinsons**	◯ Yes	◯ No
Autoimmune Disorder	◯ Yes	◯ No	**Headaches**	◯ Yes	◯ No	**Rheumatoid Arthritis**	◯ Yes	◯ No
Cancer	◯ Yes	◯ No	**Hearing Impairment**	◯ Yes	◯ No	**Seizures**	◯ Yes	◯ No
Cardiac Conditions	◯ Yes	◯ No	**Hepatitis**	◯ Yes	◯ No	**Smoking**	◯ Yes	◯ No
Cardiac Pacemaker	◯ Yes	◯ No	**High Cholesterol**	◯ Yes	◯ No	**Speech Problems**	◯ Yes	◯ No
Chemical Dependency	◯ Yes	◯ No	**High/Low Blood Pressure**	◯ Yes	◯ No	**Strokes**	◯ Yes	◯ No
Circulation Problems	◯ Yes	◯ No	**HIV/AIDS**	◯ Yes	◯ No	**Thyroid Disease**	◯ Yes	◯ No
Currently Pregnant	◯ Yes	◯ No	**Incontinence**	◯ Yes	◯ No	**Tuberculosis**	◯ Yes	◯ No
Depression	◯ Yes	◯ No	**Kidney problems**	◯ Yes	◯ No	**Vision Problems**	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No	**Metal Implants**	◯ Yes	◯ No			

Describe any other conditions or precautions

If "Yes" to Any of the above, please explain and give approximate dates / Describe any other Conditions.

Fall History

Injury as a result of a fall in the past year? ◯ Yes ◯ No
Two or more falls in the past year? ◯ Yes ◯ No
Patient is at risk for falls? ◯ Yes ◯ No

Surgical History

Body Region: _____ **Surgery Type:** _____ **Date:** _____
Body Region: _____ **Surgery Type:** _____ **Date:** _____
Body Region: _____ **Surgery Type:** _____ **Date:** _____
Body Region: _____ **Surgery Type:** _____ **Date:** _____

Current Medications ☐ *Currently not taking any medications*

Drug: _____ **Dosage:** _____ **Frequency:** _____ **Route:**_____ **Reason Taking:**_____
Drug: _____ **Dosage:** _____ **Frequency:** _____ **Route:** _____ **Reason Taking:** _____
Drug: _____ **Dosage:** _____ **Frequency:** _____ **Route:** _____ **Reason Taking:** _____
Drug: _____ **Dosage:** _____ **Frequency:** _____ **Route:** _____ **Reason Taking:** _____