Atlantic Physical Therapy Center

ATLANTICPTCENTER.COM ATLANTICHAND.COM ATLANTICPELVICHEALTH.COM

Referral Information

Past Patient: ☐YES ☐NO | Whom may we thank for referring you to us?

Patient Information

EMAIL:
(Providing email is consenting to receiving emails from Atlantic Physical Therapy Center)

Patient Name: (First, MI, Last, - Sr., Jr., etc) | Social Security #:

Address: | City | State: | Zip Code:

Please check one box as PRIMARY contact number.
☐ Home Phone: ( ) -
☐ Cell Phone: ( ) -
(Providing cell phone is consenting to receive texts. Text and data rates may apply.)

Date of Birth (mm-dd-yyyy) | Sex: ☐ M ☐ F | Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Date of Injury / Onset Date | Auto Related: ☐ Yes - State? _____ ☐ No | Work Related: ☐ Yes ☐ No | **Adjustor Name & Telephone #:**

Claim # _____

If Workers Comp, was accident with present Employer? ☐ Yes ☐ No

If No, who was employer? _____

Occupation: _____

If Auto Accident, Date of Accident:___ / ___/ __
Type of Accident: Driver / Passenger / Pedestrian / Job / Fall / Other

Do you have Medicare Insurance Coverage? ☐ No ☐ Yes Are you receiving Home Health Services? ☐ No ☐ Yes

Primary Insurance Information (Please **DO NOT** skip this section)

Name of Insurance Company: | Policy or Claim #: | Group # / Policy Holders Employer:

Policy Holder Name: | Date of Birth: | Policy Holders Phone #:

Policy Holder Address: | **Patient Relationship to Policy Holder:** ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Secondary Insurance Information (Backup if Auto is Primary)

Name of Insurance Company: | Policy or Claim #: | Group # / Policy Holders Employer:

Policy Holder Name: | Date of Birth: | Policy Holders Phone #:

Policy Holder Address: | **Patient Relationship to Policy Holder:** ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Employer Information

Employer Name: | Employer Phone #: | Employment Status: ☐ None ☐ FT ☐ PT ☐ Self-Emp. ☐ Retired ☐ Student

Address: | City | State: | Zip Code:

Emergency Contact Information

Contact Name: | Phone # | Relationship to Patient: ☐ Parent ☐ Spouse ☐ Sibling ☐ Child ☐ Other

Financial Policy

As the patient, you are responsible for knowing the policies and procedures of your insurance plan, including pre-certification requirements, limitations, maximum benefits, co-payments, etc. As a courtesy, we will submit all primary and secondary insurance billing. Any remaining balance such as co-insurance, deductible, etc. is your responsibility. If you have any questions, please speak to a member of our office staff.

I _____authorize Atlantic Physical Therapy Center to treat me as per my doctor's prescription and to release to my insurance company/Employer any information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating claims for benefits.

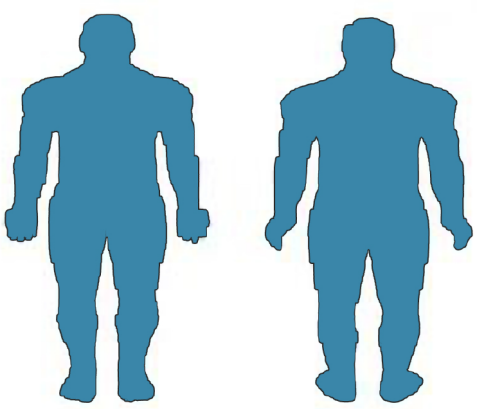
Signature: _____ Date: _____

Atlantic Physical Therapy Center Pain Profile

1. What activities increase your problem: _____
2. What activities decrease your problem: _____
3. Are you presently working? Yes ☐ No ☐ Occupation: _____
4. What do you hope to accomplish with PT? _____
5. **REQUIRED BY INSURANCE – Please provide us your Height:_____ Weight:_____**

Please shade/circle in the areas that correspond to your pain or numbness

FRONT **BACK**



Please Rate Pain
(0 = none; 10 = worst)

0
1
2
3
4
5
6
7
8
9
10

Injury Information

Work Related Injury Athletic Injury Motor Vehicle Accident Other: _____
Date of Injury / Surgery _____ Date of next doctor's visit _____

Have you ever had these symptoms before? _____

Please check any of the following that apply to you:

_____ Diabetes
_____ Chest pain / Angina
_____ High Blood Pressure
_____ Heart Disease
_____ Heart Attack
_____ Heart Palpitations
_____ Pacemaker
_____ Headaches
_____ Kidney Problems
_____ Cancer
_____ Bowel / Bladder Abnormalities
_____ Liver / Gall Bladder Abnormalities
_____ Asthma / Breathing Difficulties
_____ Smoking
_____ Osteopenia / Osteoporosis

_____ Allergies to Aspirin
_____ Allergies to Heat
_____ Allergies to Cold
_____ Other Allergies
_____ Hernia
_____ Seizures
_____ Metal Implants
_____ Dizziness / Fainting
_____ Recent Fractures
_____ Surgeries
_____ Skin Abnormalities
_____ Ringing in your Ears
_____ Nausea / Vomiting
_____ Special Diet Guidelines
_____ Rheumatoid Arthritis

Is there any information in your past medical history that we should know about?

_____

Are you presently taking any medication? _____ if yes, please list medications:

_____

Patient Name (Printed):_____

Patient Signature _____ Date _____

ATLANTIC Physical Therapy Center

OFFICIAL PHYSICAL THERAPY PROVIDER FOR THE JERSEY SHORE BLUECLAWS

HIPAA PRIVACY POLICY NOTICE

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Disclose health information in order to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment both directly and indirectly.

Disclose your health information in order to receive payment for the services we provide to you.

Disclose your health information for normal healthcare operations such as quality assessments and physician certifications.

PATIENT RIGHTS REGARDING MEDICAL INFORMATION

The Right to Inspect and Copy Your Information: You may review and copy your medical records and information.

The Right to Amend: You may ask that we amend your health information if you believe that your information is incomplete or incorrect.

The Right to Request Restrictions: You may request a restriction or limitation on how and what health information we disclose regarding you for treatment, payment of health operations or to your family or care-givers.

The Right to Confidential Communications: You may request that we communicate with you about medical matters in a certain format or a specific location.

The Right to Receive a Copy of this Notice: You may request and receive a copy of this notice (or our current notice) at any time by contacting this organization.

_____ _____

Print Patient Name | Relationship to Patient

_____ _____

Signature | Date

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:** _____

THE UROLOGY GROUP

NIH Chronic Prostatitis Symptom Index (NIH-CPSI)

NAME: _____ **DATE:** _____ **DOB:** _____

Pain or Discomfort

1. In the last week, have you experienced any pain or discomfort in the following areas?

		Yes	No
a.	Area between rectum and testicles (perineum)	☐ 1	☐ 0
b.	Testicles	☐ 1	☐ 0
c.	Tip of the penis (not related to urination)	☐ 1	☐ 0
d.	Below your waist, in your pubic or bladder area	☐ 1	☐ 0

2. In the last week have you experienced:

		Yes	No
a.	Pain or burning during urination?	☐ 1	☐ 0
b.	Pain or discomfort during or after sexual climax (ejaculation)?	☐ 1	☐ 0

3. How often have you had pain or discomfort in any of these areas over the last week?

- ☐ 0 Never
- ☐ 1 Rarely
- ☐ 2 Sometimes
- ☐ 3 Often
- ☐ 4 Usually
- ☐ 5 Always

4. Which number be describes you AVERAGE pain or discomfort on the days that you had it, over the last week?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

NO PAIN — PAIN AS BAD AS YOU CAN IMAGINE

Urination

5. How often have you had the sensation of not emptying your bladder completely after you finished urinating, over the last week

- ☐ 0 Not at all
- ☐ 1 Less than 1 time in 5
- ☐ 2 Less than half the time
- ☐ 3 About half the time
- ☐ 4 More than half the time
- ☐ 5 Almost always

6. How often have you had to urinate again less than two hours after you finished urinating, over the last week?

- ☐ 0 Not at all
- ☐ 1 Less than 1 time in 5
- ☐ 2 Less than half the time
- ☐ 3 About half the time
- ☐ 4 More than half the time
- ☐ 5 Almost always

Impact of Symptoms

7. How much have your symptoms kept you from doing the kind of things you would usually do, over the last week?

- ☐ 0 None
- ☐ 1 Only a little
- ☐ 2 Some
- ☐ 3 A lot

8. How much did you think about your symptoms, over the last week?

- ☐ 0 None
- ☐ 1 Only a little
- ☐ 2 Some
- ☐ 3 A lot

Quality of Life

9. If you were to spend the rest of your life with symptoms just the way they have been during the last week, how would you feel about that?

- ☐ 0 Delighted
- ☐ 1 Pleased
- ☐ 2 Mostly satisfied
- ☐ 3 Mixed
- ☐ 4 Mostly dissatisfied
- ☐ 5 Unhappy
- ☐ 6 Terrible

Scoring the NIH Chronic Prostatitis Symptom Index Domains

Pain: Total of items 1a, 1b, 1c, 1d, 2a, 2b, 3, and 4 = _____

Urinary Symptoms: Total of items 5 and 6 = _____

Quality of Life Impact: Total of Items 7, 8, and 9 = _____