Still Water
PHYSICAL THERAPY

PATIENT INFORMATION

Date: _____
Name: _____ DOB:_____SS#:_____
Phone: (H)_____ (W)_____
(C)_____
Address:_____ City: _____ State: _____
Zip:_____
Sex: _____ Marital Status: _____ Email Address:
_____
Occupation:_____ Employer: _____
Spouse: _____ Phone: _____
EMERGENCY CONTACT: _____ Relationship: _____
Phone: _____

Dear Customers,

This is to inform you of the office billing procedures and cancellation policy. Please read the following information carefully and sign below.

Confidentiality Statement and Medical Records Release: All information shared in this treatment is confidential except in circumstances governed by law. If you would like me to confer with another healthcare professional, you will need to sign a "Release of Information" form. This permission can be revoked by you at any time. If you have a physician who has referred you to this office, Still Water Physical Therapy will send copies of your initial, reevaluation, progress reports, and discharge summary. I also may have to send information to your insurance company. If you do not want these sent, please check here _____.

Currently, I **DO NOT** take any insurances. I will supply you with complete invoices at the time of payment so that you may submit these invoices to your insurance company. You are responsible for all payments at the time of service by cash, check, or credit card.

Financial Agreement: A standard one hour office visit is $100.00. We take cash, check, or credit card. Fees are subject to change. You are responsible for all payments at the time of service regardless of any insurance benefits, proceeds from settlement or trial. **I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS), I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED REGARDLESS OF THE DISPOSITION OF MY CLAIM. SHOULD COLLECTIONS PROCEDURES BE REQUIRED TO COLLECT ANY BALANCE OWED TO STILL WATER PHYSICAL THERAPY, PLLC FOR SERVICES RENDERED, I WILL BE RESPONSIBLE FOR ALL COURT AND LEGAL COSTS**.

No Show and cancellation policy: 24 hrs. notice is required to cancel an appointment, or you will be charged $50.00. This charge must be paid before you will be seen for your next appointment. This fee cannot be submitted to your insurance company.

I am eager to make your visits as meaningful as possible. If you need further information, please contact Kathleen Hess, PT at 703-583-6899.

I have read the information concerning confidentiality, medical records release, payment and cancellation policies for Still Water Physical Therapy, PLLC. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or any of the above information. I have asked any questions and fully understand the policies.

_____
Customer Signature and Date

_____
Kathleen Hess, PT and Date

"Committed to returning people to a healthy, pain free life"

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PHYSICAL THERAPY

Kathleen Hess, RPT
15611 Andover Heights Drive
Woodbridge, VA 22193
703-583-6899(phone/fax)

SUBJECTIVE REPORT-INITIAL EVALUATION

NAME: _____ DATE: _____
AGE: _____ HEIGHT:_____ WEIGHT:_____
REFERRING PHYSICIAN: _____
HOW DID YOU HEAR ABOUT ME? _____
OCCUPATION: _____ HOURS: _____ RETIRED: _____

PLEASE FILL OUT THIS FORM AS SPECIFICALLY AS POSSIBLE TO PROVIDE A CLEAR PICTURE OF YOUR PRESENT FUNCTIONAL ABILITY AND SYMPTOMS. Please use the back of this form to add more information if there is not enough space provided.

1. What is your primary complaint that brings you to physical therapy?_____
_____
constant / intermittent / dull aching / sharp shooting / burning / tightness / pressure / cramping, pain level #____/10 to #____/10 (usual is #____/10).
Frequency of pain: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|
0 (never) 1 2 3 4 5 6 7 8 9 10 (always)

Symptoms started in _____ due to _____
_____.

Since onset, the pain has increased / decreased / stayed the same in severity / frequency and duration.

What is your functional ability as a % of normal on a good day _____%, on a bad day _____%.

Symptoms increase with lifting / sitting / standing / walking / bending / climbing / driving / reaching / sexual intercourse/ housekeeping / social activities / cold / rainy weather / sneezing / deep breathing / coughing
Nothing decreases this pain. Pain decreases with medication / positional changes / heat / ice / rest.
_____
_____
_.
2. Do you have any secondary complaints?_____
_____.

constant / intermittent / dull aching / sharp shooting / burning / tightness / pressure / cramping, level #____/10 to #____/10 (usual is #____/10).
Frequency of pain: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|
0 (never) 1 2 3 4 5 6 7 8 9 10 (always)

Symptoms started in _____ due to _____
_____.

Since onset, the pain has increased / decreased / stayed the same in severity / frequency and duration.

What is your functional ability as a % of normal on a good day _____%, on a bad day _____%.

Symptoms increase with lifting / sitting / standing / walking / bending / climbing / driving / reaching /sexual intercourse/ housekeeping / social activities / cold / rainy weather / sneezing / deep breathing / coughing

Nothing decreases this pain. Pain decreases with medication / positional changes / heat / ice / rest.

_____

_____.

3. Other Treatments received for your current condition? Specify what treatment and for how long.

_____

_____

_____.

4. Please list any medications you are taking and how many times per day and dosage.

_____

_____

_____

_____.

5. Do you have any of the following medical conditions?

	YES	NO		YES	NO
Circulatory problems	____	____	Blackouts	____	____
High Blood Pressure	____	____	Visual Disturbances	____	____
Heart Trouble	____	____	Weight Changes > 15lbs	____	____
Pacemaker	____	____	Headaches	____	____
Epilepsy	____	____	Ringing in ears	____	____
Diabetes	____	____	Bowel/Bladder Problems	____	____
Pregnancy	____	____	Malignancy/Cancer	____	____
Stroke	____	____	Other _____		

6. Past Medical History: Please list any surgeries, traumas, accidents or other conditions that are not specified above and the dates that these incidents occurred throughout your life.

_____

_____

_____.

7. Please list the activities that you have trouble performing because of your symptoms. For each activity, please note the amount of time in minutes or hours that you can perform these activities before you feel a need to stop because of your symptoms, or how many pounds you can lift, carry, etc. If you are unable to perform an activity mark with unable. If you have no difficulty with the activity, mark OK. Please be specific since this will be what your insurance company is looking for related to progress.

Activity	Tolerance	Activity	Tolerance	Activity	Tolerance
Sitting	_____	Computer work	_____	Sleeping	_____
Standing	_____	Writing	_____	Driving	_____
Walking	_____	Bending(# of times)	_____	Vacuuming	_____
Stairs (# step or flights)	_____	Lifting(lbs)	_____	Cooking	_____
Exercise	_____	Carrying(lbs)	_____	Washing Dishes	_____
Other _____		Other _____		Laundry	_____

8. WHAT ARE YOUR GOALS FOR PHYSICAL THERAPY? Please be specific. For example, what activities from the above list would you like to be able to do or perform better or longer? How long in minutes or hours do you need or want to perform each activity?

_____

_____

_____

_____

_____

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INFORMED CONSENT

CONDITIONS OF, AND CONSENT FOR TREATMENT: I hereby request and authorize Still Water Physical Therapy and their staff to perform therapy on me. I understand that therapy includes manual (hands-on) therapy to the soft tissues and other structures of the head, trunk, chest, abdomen, low back, hips, pelvis (including urogenital areas) and whatsoever other areas they believe may be related to my condition. I consent to treatment which will include external and possibly internal vaginal and/or rectal assessment and treatment if needed. I understand internal work may be necessary in order to access certain ligaments, muscles, adhesions, joints, structures and fibrotic tissues which may be affecting my condition. You also have the right to decline any treatment that you are not comfortable receiving.

I will be treated in a private treatment room by a trained physical therapist. The therapist understands that my comfort level is very important to me. The staff follows ethical guidelines of American Medical Association (AMA) and American College of Obstetrics and Gynecology (ACOG) regarding patient draping and the right to chaperone. I will always have access to draping, including a gown and blanket, plus sheets and/or towels.

POTENTIAL RISKS AND SIDE EFFECTS: For most patients side effects from this treatment have been transient and minimal, such as soreness similar to after a gyn exam, or temporary minor soreness of the treated areas, soreness in other areas of the body following treatment, possible spotting for women after internal treatment. Patients with soreness have found relief with ice, over-the-counter anti-inflammatory medication (e.g. ibuprofen) or Epsom Salt baths. I understand, for some patients (due to inflammation, prior trauma, etc) therapy may cause discomfort, mild pain or emotional distress, but significant pain or emotional distress are rare.

Since treatment may exacerbate active infections, I agree to notify my therapist if I contract an infection. Treatment will be discontinued temporarily pending medical clearance to continue.

Regarding some specific conditions, I understand that
1. Cancer is a contraindication due to possible risk of spreading the condition. If I want to attend therapy despite this risk, I must first provide Still Water Physical Therapy with a physician's prescription specifically clearing me for deep manual therapy.
2. Endometriomas are delicate structures that could rupture with manual therapy. While rare, such a rupture could spill blood and by-products into the body, resulting in inflammation or infection which would require medical intervention and/or possible surgery. If you have Endometriomas this is a contraindication if you know you have one.
3. Patients with a history of lymphedema, radiation therapy, or lymph node resection have an increased risk of developing lymphedema following deep manual therapy. We cannot predict this risk for any patient. Since early intervention improves my chances of lymphedema being a short term effect rather than a chronic situation, I agree to contact my physician if I note increased swelling in my abdomen or extremities after therapy. If I have a history of lymphedema, I will wear my compression garments while traveling to and from therapy, and after each treatment session.

I agree to remain attentive to my condition and notify my therapist immediately if I experience any of the following: severe abdominal pain, persistent bleeding, fainting, dizziness, lightheadedness, or shortness of breath, accompanied by weakness, loss of color, or severe abdominal pain, fever, nausea or vomiting. Should these persist, I will seek emergency medical help to rule out serious or life-threatening conditions.

RESULTS NOT GUARANTEED: Like most health care procedures, the results of this treatment procedure cannot and have not been guaranteed and I have been given no promises with respect to the effectiveness of the treatment procedure.

PHYSICIAN SCREENING: I have been advised to consult my physician prior to treatment in order to minimize any potential risk for complications. By signing below, I state that I have been cleared by my physician for any conditions which would be contraindications to treatment. These include, cancer, hemophilia, abnormal cysts, abnormal bleeding, active infection or inflammation, HIV, endometrioma, and any condition which may be exacerbated by manual therapy treatment to the soft tissues, bony or ligamentous structures of my body, including the head, chest, back, abdomen, pelvis, hips, arms, or legs.

THERAPIST TRAINING: I understand that the therapist is a licensed physical therapist in the state of Virginia who does not claim to be a physician authorized or licensed to diagnose medical conditions nor to practice medicine. I understand that their experience, training and educational background is limited to that required of their respective profession in the state in which they practice. As a result, the healthcare professional do not and cannot provide medical care.

WISH TO UNDERGO TREATMENT: Having been advised and having the general understanding of the treatment procedure and the potential risks involved, under all the surrounding circumstances, I wish to undergo the procedure above described.

I CERTIFY THAT I HAVE READ THE CONTENTS OF BOTH PAGES OF THS DOCUMENT. I UNDERSTAND THE BASIC NATURE OF THE PROCEDURE AND THE RISKS INVOLVED. I DO NOT DESIRE ANY FURTHER EXPLANATION. ALL BLANKS OR STATEMENTS REQUIRING INITIALS, INSERTION, DELETION OR COMPLETION WERE FILLED IN OR CROSSED OUT BEFORE I SIGNED.

_____

Patient signature Date

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List 5 Functional Problems You Have Due To Your Condition

Functional Problems are things that you do during the day that your pain gets in the way of you doing for example dishes, stairs, running, walking, squatting, bending, reaching, vacuuming, and computer work. Please specify how long you are able to perform these activities before the pain stops you. Please take your time with this, this is very important for insurance reimbursement.

1. _____

2. _____

3. _____

4. _____

5. _____

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our commitment here at Still Water Physical Therapy, PLLC is to serve our customers with professionalism and caring, being sure all times to protect the privacy and security of all Protected Health information.

During the course of serving your interests, it may be necessary to share information with other health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During treatment, we may need to consult with another therapist or get a second opinion.
- For payment purposes, we may use the services of a billing service.
- For payment purposes, we may need to provide progress notes and evaluations to your insurance company.
- All evaluations are forwarded to your physician via fax or the postal system.

We here at Still Water Physical Therapy, PLLC are committed to obeying all Federal, State, and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. The individual, as provided for by law, may revoke this written authorization at any time.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Privacy Officer, Kathleen Hess, RPT at 703-583-6899.

I have read and understand the above Notice of Privacy Practices.

Signed _____ Date _____
(Patient or Legal Guardian)

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