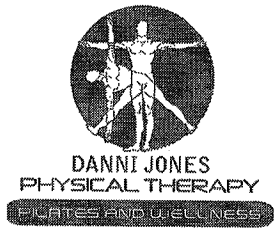
Patient Name: _____



Danni Jones Physical Therapy Policies

Welcome to Danni Jones Physical Therapy!

We are pleased that you have chosen to allow us to serve you for your Physical Therapy needs. We strive to provide highly skilled, compassionate, and progressive physical rehabilitation with an emphasis on one on one care.

Financial Policy

1. All Co-payments, Co-insurance and Deductibles are due at the time of service for all patients.
2. If you are the guarantor for a minor's account please make arrangements with our Front Desk Personnel regarding payments for services.
3. Forms of payment include: Cash, Check, Debit Card, Visa, American Express, Discover, or MasterCard.

Insurance Benefits Policy

1. Danni Jones PT will bill your primary and secondary insurance carriers as a courtesy to you. However, patients who have health care insurance should understand that charges for professional services are charged to the patient and not to the insurance company. **You are ultimately responsible for payments for all services rendered.**
2. To enable us to provide this service for you, you must:
    a. Provide us with necessary and correct insurance information for billing to be done correctly and timely.
    b. Notify us if any part of your insurance coverage information changes during the course of treatment.
    c. If you elect not to provide all necessary information for billing your insurance company you will be treated as a cash patient and will receive a "superbill" that you may use to submit your bills directly to your payer for reimbursement.
3. You agree to pay for all charges that are **not covered** by your insurance plans.
4. If charges billed to your insurance company on your behalf are not paid by your insurance company within a reasonable time, the overdue amount will become your full responsibility and payment will be due at that time. (It will then become your

responsibility to resolve the outstanding issue with your insurance company and receive your reimbursement from them.)

a. Most insurance companies pay within 3-4 weeks.

b. You can help facilitate payments on your account by reviewing your Explanation of Benefits (EOB) and responding to any requests in a timely manner. Please notify us immediately if a payment is denied.

Patient Billing Process:

We will make every attempt to process all of your claims in a correct and timely manner. Once your insurance company begins making payments on your account, you will receive a monthly statement to inform you of your account status.

No Shows

Our time is valuable in order to properly serve patients in the best manner they need, each appointment is important, therefore we ask that you notify us at least 24 hours in advance if you know you cannot make your appointment. That way we can give your time to another patient in need. If a series of NO Shows happens then a $25 charge will be given.

Acceptance of Financial Policy:

1. I have read and understand the financial policy of Danni Jones Physical Therapy.
2. I agree to assign insurance benefits to Danni Jones Physical Therapy whenever necessary.
3. I agree to pay any and all balances due and understand that Danni Jones Physical Therapy will not hold accounts for payment.
4. I understand that if I do not pay my account as designated, my debt may be presented in Small Claims Court for judgment, or sent to a professional collection agency.
5. I accept the No Show Policy and will give proper advance notification if I need to cancel my scheduled appointment.

By my signature below I agree to be financially responsible for payments of all services received.

_____ _____

Patient's Signature Date

_____ _____

Signature of the person responsible for the bill if not the patient or if patient is a minor Date

Thank you for choosing us for your Physical Therapy needs.

PATIENT INFORMATION

Name _____ **Soc. Sec. #** _____
Last name *First Name*

Address _____

City _____ **State** ____ **Zip** _____ **Home Phone** _____

E-mail _____ **Cell** _____

Would you like to receive appointment reminders via Text □**Yes** □ **No**

Would you like to receive electronic billing via Email? Email □**Yes** □ **No**

Sex □ M □ F **Age**_____ **Birthdate** _____ **Marital Status** _____

Employer/School _____ **Occupation/Grade** _____

Work Phone _____

Primary Insurance Holder _____ **DOB:**_____
Last Name *First Name*

Secondary Insurance (if applicable) _____
Last Name *First Name*

Person responsible for the account _____
(Please list attorney if applicable here)

In case of emergency, who should be notified _____

How did you hear about Danni Jones Physical Therapy?

□ Friend: _____ □ Social Media

□ Doctor: _____ □ Search Engine (i.e. google)

□ Website □ Other: _____

Have you received physical therapy at another location this year? □ Yes □ No

If yes, how many visits have you received? _____

Date of next physician's visit: _____

Date of injury / onset: _____

Are you presently seeing an attorney for this injury? □Yes □ No

If so, please provide your attorney's information:

_____

_____

For Medicare Patients Only:

Have you or are you currently receiving Home Health? □Yes □ No

If so, approximate date of discharge from Home Health? _____

DANNI JONES
PHYSICAL THERAPY
& WELLNESS

PELVIC INTAKE FORM

Patient Name: _____ Date: _____ DOB: _____

Age: _____ Weight: _____ Gender: Male Female

Occupation: _____ Relationship Status: _____

Hobbies / Leisure Activities:

_____

Exercise Routine:

_____

Briefly describe your current complaint:

_____

_____

Rate your feelings as to the severity of this problem: 0 1 2 3 4 5 6 7 8 9 10
0 = not a problem 10 = major problem

Do you now have or do you have a history of the following?

- ☐ Bladder infections
- ☐ Urinary frequency, hesitancy, urgency
- ☐ Pelvic pain
- ☐ Low back pain / sciatica
- ☐ Multiple Sclerosis
- ☐ Childhood bladder problems
- ☐ Trouble holding back gas
- ☐ Vaginal dryness
- ☐ Constant dribbling of urine
- ☐ Interstitial cystitis / Painful Bladder
- ☐ Constipation, IBS, chronic diarrhea
- ☐ Chron's Disease
- ☐ Joint problems
- ☐ Abdominal pain
- ☐ Emphysema / bronchitis
- ☐ Sexually transmitted diseases
- ☐ HIV / AIDS
- ☐ Fecal incontinence
- ☐ Smoking habit
- ☐ Blood in urine
- ☐ Trouble feeling bladder fullness
- ☐ Pelvic Organ Prolapse:
  - ☐ Type:
  - ☐ Grade:
- ☐ Cancer Type:

  _____
- ☐ Sleep disorders
- ☐ Drug addiction
- ☐ Fatigue, Chronic Fatigue Syndrome
- ☐ Fibromyalgia
- ☐ Allergies:

  _____
- ☐ Other (please list):

OB/GYN History (if appropriate):

Contraceptive History – Currently using a form of birth control? Y / N

Type of contraception used (condom / pill / IUD / implantable / cervical fluid): _____

If oral contraceptives, how long were they taken? _____

Vaginal deliveries: _____ # C-section: _____ # Episiotomies: _____ Forceps Y / N

Complication with delivery / postpartum: _____

Pelvic Surgical History: _____

_____

Menstrual Surgical History: Age at onset? _____ Date of last menstrual cycle: _____

Y / N Painful periods? Y / N Pain with ovulation?

Y / N Regular cycle? Y / N Menopause?

Y / N Painful with tampon insertion? Y / N Hormonal Treatment?

Any other significant factors in OB/GYN history, please describe:

_____

_____

Sexual Function: For pelvic health, sexual function is an important component to be addressed. These questions are helpful in creating a complete treatment plan for you. However, please know you may choose not to disclose many portions of the following information.

Please circle any applicable items:

Are you currently sexually active? Y / N / It's complicated

Orgasm, erectile, clitoral function – check any that apply

- ☐ Premature Ejaculation
- ☐ Lack of orgasm
- ☐ Painful penetration (vaginal / rectal)
- ☐ Pain with orgasm
- ☐ Difficulty with erection
- ☐ Arousal without completion
- ☐ Painful ejaculation
- ☐ Low libido / lack of desire
- ☐ Nocturnal erections

Y / N History of sexual abuse? Y / N Latex allergy?

Y / N Leakage of urine during intercourse? Y / N Lubricant allergy / sensitivity

If you use a vaginal or rectal lubricant, what type do you use? _____

Bladder / Bowel Habits:

Number of times you urinate during the day? 3-5 6-9 10-13 >13

Number of times you urinate after going to bed? 0 1-2 2-3 >3

# of bowel movements per day? 0-1 1-2 2-3 >3

Consistency of stool: Loose Normal Hard

Y / N Do you take your time to empty your bladder?

Y / N Does your bladder feel full after urination?

Y / N Can you stop the flow of urine?

Y / N Do you empty your bladder frequently, before the urge?

Y / N Do you have a slow, hesitant urine stream?

Y / N Do you strain to pass feces?

Y / N Do you strain to pass urine?

Y / N Do you ignore the urge to defecate?

Y / N Do you have triggers that make you feel you can't wait to urinate or defecate?

Fluid intake per day (one glass is 8oz or one cup): 1-2 2-3 3-4 4-5 > 5

Number of caffeinated glasses per day: 0 1-2 2-3 3-4 4-5 > 5

Number of alcoholic glasses per day: 0 1-2 2-3 3-4 4-5 > 5

Urine / Fecal Leakage Questions:

Number of urinary leakages daily: 1 2 3 4 5 > 5

Number of fecal / bowel leakages daily: 1 2 3 4 5 > 5

Severity of Leakage: None Few drops Wets underwear Wets outerwear

Protection worn: None Minipad Maxipad Full undergarment

Position or Activity with Leakage:

- ☐ Vigorous activity
- ☐ Light activity
- ☐ Changing Positions
- ☐ Walking to toilet
- ☐ Strong urge to go
- ☐ Intercourse or sexual activity
- ☐ No activity changes leakage (constant)

Pelvic Pain Questions:

"I have pain with…"

- ☐ Sexual intercourse
- ☐ Urination
- ☐ Defecation
- ☐ At Rest
- ☐ Sitting
- ☐ Standing
- ☐ Tight clothes
- ☐ Exercise
- ☐ Menstruation
- ☐ Orgasm

"Pain is located…"

- ☐ Deep
- ☐ Surface
- ☐ Vagina
- ☐ Urethra
- ☐ Anus
- ☐ Penile shaft
- ☐ Penile tip
- ☐ Clitoris
- ☐ Labia
- ☐ Scrotum
- ☐ Hip
- ☐ Pubic
- ☐ Rectum
- ☐ Tailbone / coccyx
- ☐ Tailbone / sacrum
- ☐ Pubic bone
- ☐ Right side / left side / both sides

Approximate pain onset date: _____

Pain is relieved by: _____

Pain is worsened by: _____

Medications, supplements, herbals or topicals: _____

_____

INFORMED CONSENT:

I understand that as a patient of Danni Jones Physical Therapy I am choosing to participate in a physical therapy evaluation at my own risk. An evaluation includes medical history review and physical examination.

I understand that following the evaluation the complete findings of the evaluation, the treatment options and risk, and the prognosis will be communicated as clearly as possible to a level I can understand by my physical therapist and that I have the right to choose whether I participate.

I will receive the most effective care the clinic provides. I have the right to accept medical care or to refuse treatment to the extent permitted by law and to be informed of the medical consequences if I refuse treatment.

I understand that if I refuse recommended treatment, Danni Jones Physical Therapy has the right to terminate the relationship with me.

I will be informed if Danni Jones Physical Therapy wishes to participate in or perform any research or educational projects that would affect my care.

Patient Signature: _____ **Date:** _____

Notice of Privacy Practices Policy (HIPAA):

This is a policy providing information regarding the handling of your personal information and medical history according to HIPAA requirements. This policy is available on our website with this link:
https://www.dannijonespt.com/downloads/notice_of_privacy_practices-hipaa.pdf
or you may request a copy.

Patient Signature: _____ **Date:** _____

CREDIT CARD SAVED

I give Danni Jones Physical Therapy permission to charge my credit card that is saved on file. The charge that will be made is for my daily charge, not my outstanding bill

Patient Signature: _____ Date: _____

___ Charge Each Visit

___ Charge My Card One Time for My Visits for The Week