PEDIATRIC CONSENT FOR EVALUATION AND TREATMENT

Informed consent for treatment: The term “informed consent” means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, 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 or bladder functions, or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform a pelvic floor muscle examination. **This examination is performed primarily by observing and/or palpating the external perineal region. No internal examination is done.** This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, and function of the pelvic floor region.

Treatment may include, but not be limited to the following: observation, palpation, biofeedback and/or electrical stimulation, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

Potential risks: I may experience an increase in my current level of pain or discomfort if any, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my physical therapist.

Potential benefit: I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Release of medical records: I authorize the release of my medical records to my physicians/primary care provider or insurance company.

Cooperation with treatment: I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

No warranty: I understand that the therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of treatment for my condition and will discuss all treatment options with me before I consent to treatment. I have informed my therapist of any condition that would limit my ability to have and evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists and therapy assistants and technicians of The Pelvic FIxx.

Date_____ Patient Name: (Please Print)_____
Patient Signature_____

Signature of Parent or Guardian (If applicable)_____Witness Signature_____

PEDIATRIC HEALTH HISTORY AND SCREENING QUESTIONNAIRE

Patient History and Symptoms Your answers to the following questions will help us to manage your child's care better. Please complete all pages prior to your child's appointment.
Name of parent or guardian completing this form _____
Child's name: _____ Prefers to be called _____
Age: ___ Grade: _____ Height: _____ Weight:_____
Describe the reason for your child's appointment:_____
When did this problem begin?_____
Is it getting better, worse, variable, staying the same, variable? (circle one)
Name and date of child's last doctor visit:_____ Date of last urinalysis: _____
Previous tests for the condition for which your child is coming to therapy. Please list tests and results: _____
Medications:_____ _____
_____ _____ _____
Has this condition stopped your child from participating in activities? Yes/No
Does your child now have or had a history of the following? Explain all "yes" responses below.
Pelvic pain Y/N Blood in urine Y/N Low back pain Y/N
Kidney infections Y/N Diabetes Y/N Bladder infections Y/N
Latex sensitivity/allergy Y/N Vesicoureteral reflux Grade ____ Y/N Allergies Y/N
Neurologic (brain, nerve) problems Y/N Asthma Y/N Physical or sexual abuse Y/N
Surgeries Y/N Other (please list)
Explain yes responses and include dates:_____
Does your child need to be catheterized? Y/N If yes, how often?_____

Bladder Habits:
1. How often does your child urinate during the day? _____times per day, every ___ hours.
2. How often does your child wake up to urinate after going to bed? _____ times
3. Does your child wake up wet in the morning? Y/N If yes, _____days per week.
4. Does your child have the sensation (urge feeling) that they need to go to the toilet? Y/N
5. How long does your child delay going to the toilet once he/she needs to urinate? (Circle one)
___ Not at all ___ 1-2 minutes ___ 3-10 minutes __ 11-30 minutes ___ 31-60 minutes ___hours
6. Does your child take time to go to the toilet and empty their bladder? Y/N
7. Does your child have difficulty initiating the urine stream? Y/N
8. Does your child strain to pass urine? Y/N
9. Does your child have a slow, stop/start or hesitant urinary stream? Y/N
10. Is the volume of urine passed usually: Large Average Small Very small (circle one)
11. Does your child have the feeling their bladder is still full after urinating? Y/N
12. Does your child have any dribbling after urination:(once they stand up from the toilet?) Y/N
13. Fluid intake (one glass is 8 oz or one cup) ___ of glasses per day (all types of fluid)
___ of caffeinated glasses per day Other types of drinks _____
14. Does your child have "triggers" that make him/her feel like he/she can't wait to go to the toilet? (i.e. running water, etc.) Y/N please list_____

Bowel Habits

15. Frequency of movements: ___ per day per week. Consistency: loose__ normal___ hard__
16. Does your child currently strain to go? Y/N Ignore the urge to defecate? Y/N
17. Does your child have fecal staining on his/her underwear? Y/N How often?_____
18. Does your child have a history of constipation? Y/N How long has it been a problem?_____

SYMPTOM QUESTIONNAIRE

1. **Bladder leakage** (check all that apply)
___ Never ___ When playing ___ While watching TV or video games ___ With strong cough/sneeze/physical exercise ___ With a strong urge to go ___ Nighttime sleep wetting
2. Frequency of urinary leakage-number (#) of episodes ___ # per month ___ # per week ___ # per day ___ Constant leakage
3. Severity of leakage (circle one) ___ No leakage ___ Few drops ___ Wets underwear ___ Wets outer clothing
4. **Bowel leakage** (check all that apply) ___ Never ___ When playing ___ While watching TV or video games ___ With strong cough/sneeze/physical exercise ___ With a strong urge to go
5. Frequency of bowel leakage-number (#) of episodes ___ # per month ___ # per week ___ # per day
6. Severity of leakage (circle one) ___ No leakage ___ Stool staining ___ Small amount in underwear ___ Complete emptying
7. Protection worn (circle all that apply) ___ None ___ Paper towel ___ Diaper ___ Pull-ups
8. Ask your child to rate his/her feelings as to the severity of this problem from 0-10 _____

Medical History Please mark Yes or No for each of the following. Any YES answers please explain.

Cardiovascular System:_____
Pulmonary System:_____
Gastrointestinal & Urogenital System: (circle all that apply)
Diarrhea or constipation Abdominal pain Pain or difficulty when urinating
Leak urine w/cough, sneeze or exercise Changes in menstruation pattern (female)
Currently pregnant Yes/No
Nervous System/Musculoskeletal: _____
Neurological problems:_____
Cancer: _____
Surgeries:_____
Diabetes: Yes/No

Patient Registration and Authorization Form Please Print

Today's Date:_____ Diagnosis: _____

DOB:_____ Patient Name: First_____ Last_____

Social Security #:_____ Male_____ Female_____

Married___Single___Widowed___ Does Not Apply _____

Home Address: _____
City:_____State:_____Zip Code:_____

Phone Numbers: Home: _____Cell: _____ Work:_____

Email Address:_____

Referring Physician: _____ Phone #_____

Primary Care Physician: _____ Phone # _____

Emergency Contact:_____Phone # _____
Relationship:_____

The undersigned agrees to be ultimately responsible for payment of all charges for services rendered by The Pelvic Fixx whether or not such services are covered by insurance benefits. The undersigned agrees to reimburse The Pelvic FIxx for any expenses, including reasonable attorney fees, incurred in connection with the collection of sums due for services performed hereunder.

Patient/Responsible Party Signature: _____ Date: _____

Policies and Procedures
Please read and initial each paragraph and sign the last page

The Pelvic Fixx takes the quality of your health care very seriously. Our model enables us to provide the highest level of specialized care possible. Unlike other physical therapy practices, we are proud to offer one-hour individual appointment sessions with a licensed physical therapist/PTA who specializes in treating complex conditions. Our patient centered, holistic approach allows exceptional results and a high rate of patient satisfaction.

_____ (initial) **Payment Policy**: **Cash Option:** Our fee is $150 for Initial evaluation and $100 for each additional visit. Please come prepared to make a payment at each visit. We accept cash, check and major credit cards. We require a credit card to be maintained on file for charging visit fees, medical supplies, no show and late cancel fees. To avoid the charges being run on the credit card on file you may still pay for patient responsible charges with cash, check or HSA/FSA cards by presenting these at the front desk prior to your treatment. At the end of each treatment session, you will receive an itemized bill that you can submit to your insurance company. Although we are here to assist you with understanding your insurance coverage, any reimbursement from an insurance company is the responsibility of the patient.

_____ (initial) **Payment Policy: Medicare Patients/Insurance** I hereby agree to pay any and all charges that are not covered by my insurance plan, such as deductible, coinsurance, copayments, medical supplies, no show and late cancel fees. We require a credit card to be maintained on file for charging any fees determined to be patient responsibility. You may still pay for patient responsible charges with cash or check prior to your treatment to avoid the charges being run on the credit card on file.

_____ (initial) **Cancellation Policy:** Please contact our office at least 24 business hours prior to your scheduled appointment to notify us of any cancellations. If 24-hour notification is not given, you will be charged $40 for the missed appointment. This amount will be collected directly from your credit card on file. To cancel a Monday appointment, please call our office by 4:00 p.m. on Friday. If over the weekend you need to cancel a Monday appointment, please leave a message as soon as possible so we can attempt to fill the appointment first thing Monday morning.

_____ (initial) **No Show Policy:** If you fail to show up for a scheduled appointment a $40 no show fee will be charged to you. This amount will be collected directly from your credit card on file.

_____ (initial) **Late Policy:** If you think you will be late for your scheduled appointment please call and inform us. We will try to accommodate you however your treatment session time may be reduced in order to remain on time for the courtesy of the next scheduled patient. If you are late you will still be charged for your full hour treatment session.

_____ (initial) We do understand that unforeseen matters of sickness or emergencies occur that you cannot control. Unfortunately we still need to charge for these missed appointments. Thank you for your understanding and cooperation.

_____ (initial) **Appointment Reminders:** We offer automated reminder phone calls, text messages or emails as a courtesy to our clients, however it is ultimately your responsibility to attend your scheduled appointment. Please be sure that the phone number or email you have provided us is correct in order to receive these reminder messages. **I prefer to receive appointment reminders by: Please circle one: Phone Call/ Email/ Text Message/ None. Please list the appropriate phone number or email:**

_____

._____ (initial) **HIPAA:** I have read and understand I have rights to a copy of The Pelvic FIxx privacy notice. I have the right to request restrictions on the use of my information and to revoke my consent at a later date. Thank you for trusting us with your specialized physical therapy needs. I have read and fully understand the above policies and procedures of The Pelvic Fixx. and agree to these terms.

Signature of Patient/Responsible Party: _____Date: _____