Strength
& Flexibility

WILLOW PHYSICAL THERAPY

2555 PHILLIPS FIELD RD, SUITE 202 FAIRBANKS, AK 99709 (907) 456-5990 Ph (907) 374-8023 Fax

MEN'S HEALTH

Today's Date_____

Name_____ (circle one) **M / F** **Birth Date**_____

Mailing Address _____ City_____ ST____ Zip_____

Physical Address_____ City_____ ST____ Zip_____

Soc. Sec. #_____

Employer_____ ***Work Phone***_____

Home #_____ Cell # _____ Emergency contact: _____#_____

Appointment reminder? ___Yes ___No ___ EMAIL ___CALL HOME PHONE or ___TEXT CELL

EMAIL address: _____

How did you hear about Willow Physical Therapy?
Internet __ TV Commercial __ Phone Book __Radio __ Newspaper __ Friend __ Dr. __ Other:_____

Date of Injury_____ * Auto _____*in which state* ? _____ * Work Comp____ * Other_____

MEDICARE PATIENTS: Are you **CURRENTLY** enrolled in **HOME HEALTH CARE?** YES____ NO_____

Primary Insurance Information

Ins. Co Name_____
ID #_____

Group #_____

Pol. Holder _____
Phone#_____ ***Birth Date***_____

*Relation to Patient*_____

Secondary Insurance Information

Ins. Co Name _____
ID #_____

Group #_____

Pol. Holder _____
Phone#_____ ***Birth Date***_____

*Relation to Patient*_____

The following person(s) may contact Willow Physical Therapy regarding my appointments, treatment, and/or billing information :

NAME:_____

RELATIONSHIP:_____

*** NAME:_____

*** RELATIONSHIP:_____

SIGNATURE:_____

PT_____

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PATIENT/FINANCIAL AGREEMENT

PATIENT NAME: _____

Willow Physical Therapy is a licensed provider whose physical therapists develop individualized treatment plans to address your unique therapy needs. Following your initial examination, we develop a specific plan of care and will work with your primary care practitioner as needed to coordinate your care. We are pleased to serve your physical therapy needs and encourage your feedback to alert us to anything we can do to provide you the highest quality of care.

As a courtesy to you Willow Physical Therapy will bill your insurance carrier for rendered services. Each healthcare insurance payer has different guidelines for allowing coverage of physical therapy services which you as the insured are responsible to know. For example, Medicare has a limit on the amount of physical therapy services that they pay for; physical therapy treatment will continue if care is deemed medically necessary. All patients approved for physical therapy services, regardless of insurance, are responsible for any and all charges not paid for and deemed "patient responsibility" by their respective insurance carriers. Payments for deductible, co- payments and non-covered services are due on date of service.

Monthly statements, if applicable, are billed to you and payment is due upon receipt. We accept cash, personal checks, money orders, and credit cards VISA & MasterCard. There will be a $30 fee for all returned checks. Please contact Deborah Mursch in our Billing Office at 907- 456-5990 if you have questions about your bill.
ALL BALANCES DUE PAST 90 DAYS WILL BE TURNED OVER TO CORNERSTONE CREDIT SERVICES

Patients Filing to no Insurance - Cash Patient Financial Agreement

Charges are as follows 1 hour visit = $200.00 each, ¾ hour visit = $150.00 each, ½ hour visit = $100.00 each

Full payment will be expected to be paid on the date of services. Initial (if applicable) _____

Should you or your caregiver experience a situation that requires the attention and resolution of a Manager, please contact our practice either by phone or in writing. Our Manager will interact with you to reach a resolution of any identified situation where our quality of service has been compromised. We use such situations to alert us to improvements we can make to better serve all of our patients.

I was given the opportunity to receive a Willow Physical Therapy HIPAA Privacy Statement. **Initial_____**

PATIENT FINANCIAL STATEMENT OF AGREEMENT

1. My signature below signifies that I have read and understand this Financial Agreement for Willow Physical Therapy to provide me physical therapy services. I agree to the terms in this patient agreement and agree to comply. I understand that if I fail to follow the terms of this agreement, I could be discharged from service.
2. I authorize the release of any medical information necessary to process my insurance claims.
3. I authorize any payments of medical benefits to be paid directly to Willow Physical Therapy.

Signature of Patient or Personal Representative (Or Witness if signature is by mark) **Date**

_____ _____

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APPOINTMENT CANCELLATION / NO SHOW POLICY

We will schedule your follow up appointments after your first visit. To facilitate the effectiveness of your treatment it is important to be consistent with your appointments.

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for appointments to be **cancelled during office hours and at least 48 hours in advance**. **This will allow other patients to fill that time frame**. Our therapists want to be available for your needs and the needs of all of our patients. When a patient cancels or does not show up for a scheduled appointment, another patient loses an opportunity to be seen. If you are unable to keep your appointment and 48 hour notice is not given, you will be assessed a **$50.00 fee**. **This fee will not be covered by your insurance company.** Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no show, and those appointments not cancelled within 48 hours.

We reserve the right to dismiss patients for chronic missed appointments.

Thank you for being a valued patient and for your understanding and cooperation. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

PATIENT STATEMENT OF AGREEMENT

My signature below signifies that I have read, understand and agree to this policy for Willow Physical Therapy to provide me physical therapy services.

I understand that if I fail to follow the terms of this agreement, I could be discharged from service.

Signature of Patient or Personal Representative: Date: (Or Witness if signature is by mark)
Printed Name of Personal Representative or Witness Description of Personal Representative's Authority:

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Patient's History of Male Condition

Name: _____ **Today's Date:** _____

Age: ____ **Date of Birth:** _____ **Sex:** ____ **Marital Status** _____ **# Children** _____ **Ages** _____

Occupation: _____ **R-handed**____ **L-handed**____ **Ht.**_____ **Wt.** _____

Please describe your main problem: _____
_____
When did it begin? _____Can you identify a cause? _____

Pain rating: Indicate your CURRENT level of pain by circling the appropriate number on the scale below:

0 1 2 3 4 5 6 7 8 9 10
| _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
No Pain *Mild Pain* *Moderate Pain* *Severe Pain* *Worst Possible*

Please describe your symptoms (sharp, dull, aching, burning, etc) _____
_____

What activities/positions make your problem worse? _____
_____

What activities/positions make your problem better? _____
_____

Do you have numbness, tingling, or weakness? If yes please describe. _____

Do you feel your problem is getting better, worse, or staying the same?_____

When was your last pelvic/rectal examination? _____

Have you had any special tests to evaluate your current problem? (MRI, urinalysis, urodynamics, ultrasound, etc)
If yes, please describe and state results: _____
_____

Have you had previous pelvic/abdominal surgery? Please describe and provide dates. _____
_____
_____

Do you have a history of bladder infections? _____ If so, how many per year? _____

Bladder Symptoms
Is it ever difficult to begin urinating? _____ Do you strain to empty your bladder? _____
Do you leak urine? ____ If yes, How often: _____ times per day _____ times per week _____ times per month
With what activities do you leak? _____ How severe (circle one): Few drops Wet underwear Wet outer wear
Do you ever have pain or burning when you urinate? _____ Can you hold your bladder if you have an urge?_____

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Patient's History of Male Condition

Name: _____ **Today's Date:** _____

Bowel Symptoms
Do you strain to have a bowel movement? _____ Have pain with a bowel movement? _____
Can you hold a bowel movement if needed? _____ Do you experience loss of stool?_____, if so how often _____
Take laxatives/enema regularly? _____ Have diarrhea often? _____

Other Information
Are you sexually active? _____ Have you ever had pain or leakage during intercourse? _____
Difficulty achieving erection?_____ Difficulty maintaining erection?_____ Pain with erection/ejaculation?(circle)_____
Have you ever had a sexually transmitted disease? _____

Have you ever been taught to do Pelvic Floor Muscle or Kegel exercises? _____

Medication Record:
Please list all current medications, with dosages (Include prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements). If you already have a list (including dosage amounts) please check here and provide a copy of the list to your therapist at the time of your evaluation _____ (Patient initials)

Current Medications:	Dosage (units or mg)	Frequency (times per day)	Administered route (oral, injection, topical, etc.)	Reason for taking medication

Use additional sheet if more space is needed

Medical History (Is there anything else that may affect your care, i.e, prostatectomy, cancer, heart attack, diabetes, fractures, etc.)

_____

_____

_____

_____

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Patient's History of Male Condition

Name: _____ **Today's Date:** _____

Where do you currently live?

__ Private Home __Private Apartment __Rented Room __Group Home __Assisted Living __Skilled Facility __Other

Who do you live with? __Live Alone __Spouse/Significant Other __Child/Children __Other Relative __Other

Job Description/Social Activities: (physical tasks, amount of sitting, lifting, computer work etc.): _____

_____

What are your goals for your course of physical therapy? _____

_____

At the present time, would you say your health is excellent, very good, fair, or poor? _____

_____ _____
Patient Signature Date

_____ _____
Evaluating Physical Therapist Signature Date