Inner Circle Physical Therapy & Myofascial Release Centers

PATIENT INFORMATION

Date of Illness or Injury _____

SSN # _____ Cell Phone # _____

Patient's Name _____

Patient's Address _____

City _____ State _____ Zip _____

Email Address:_____

In case of emergency contact: Name _____ Phone # _____
Relationship _____

Patient's Phone # _____ Referred By _____

Patient's Date of Birth _____ Age_____ Sex_____

Patient's condition related to: ____employment _____auto accident _____other

Patient status: _____single _____married _____divorced _____widowed _____ partnered
Are you a student: _____full _____part-time _____not enrolled

Employers Name/Address _____

Occupation _____ Work Phone # _____

Insurance Information (If an MVA or Workers' Compensation accident, list that insurance as your primary and then any other insurance as your secondary)

Primary Insurance Company_____Adjuster Phone Number_____
Address_____
Policy #_____ Claim #_____
Group # _____
Person Responsible for Account_____
Relationship to Patient_____ Birthdate_____ Social Security #_____

Secondary Insurance
Is Patient covered by additional insurance? _____
If so, what company and address? _____
Policy # _____ Group # _____

Lawyer's Name and Address_____
_____Phone #_____

Primary Physician_____ Diagnosis_____

Address_____City_____State_____

Zip_____ Phone #_____

Inner Circle Rehabilitation

Medical History

Past medical history and review of symptoms

Please check (√) if you have had problems with, or are presently complaining of any of the following:

☐ Asthma	☐ Diabetes	☐ Cancer	☐ Heart Disease	☐ Chest pain
☐ Palpations	☐ Lightheadedness	☐ Pneumonia	☐ T.B.	☐ Hay Fever
☐ Abdominal pain	☐ Nausea	☐ Vomiting	☐ Thyroid Disease	☐ Headache
☐ Kidney Disease	☐ Skin Disease	☐ Blood Disorders	☐ Venereal Diseases	☐ Anxiety
☐ Depression	☐ Anemia	☐ Alcohol abuse	☐ Gout	☐ Epilepsy
☐ Multiple Sclerosis	☐ Stroke	☐ Ulcers	☐ Arthritis	☐ AIDS
☐ Vascular Disease	☐ Tobacco Use	☐ Alcohol Use	☐ DVT/Blood Clots	☐ Steroids
☐ High Blood Pressure		☐ Shortness of Breath		☐ Hepatitis/Jaundice

What is your goal for coming to Physical Therapy?_____

Medications

Please list all medications you are currently taking

_____ _____ _____

_____ _____ _____

Please list all allergies you have

_____ _____ _____

Family History

Has any member of your family (including parents, grandparents, siblings) ever had the following?

Illness	Which family member?	Approximate age when diagnosed
Cancer (describe type)	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental Disease (anxiety, depression)	_____	_____
Bleeding Disease	_____	_____
Other	_____	_____

Surgical History

Please check off any surgeries listed below and when it took place. Also list any complications.

_____Back/Neck _____Kidney _____Bladder repair _____Hernias

_____Gallbladder _____Appendectomy _____Robotic Prostatectomy

_____Radical Prostatectomy _____Radiation _____Other

Male Pelvic Pain/Incontinence Questionnaire

To ensure that you receive a complete and thorough evaluation, please answer the following questions. If you are unsure how to answer any questions, please circle them. A Therapist will review this questionnaire with you as part of your first visit. **Thank you!!**

Name _____ **Date of Birth**_____
Primary reason for physical therapy_____
Date of onset of symptoms_____

Medical History: Please check if you have ever had:

☐ Arthritis	☐ Head Injury	☐ Repeated infections
☐ Broken bones/fractures	☐ Multiple Sclerosis	☐ Urinary Tract Infections
☐ Osteoporosis	☐ Back pain/Back Surgery	☐ Bacterial/Non Bacterial Prostatitis
☐ Blood disorders	☐ Hip pain/hip surgery	☐ Hemorrhoids
☐ Circulation/vascular problem	☐ Parkinson's disease	☐ Hernia
☐ Heart problems	☐ Seizures/epilepsy	☐ Ulcers/stomach problems
☐ High blood pressure	☐ Allergies	☐ Benign Prostatic Hypertrophy
☐ Lung problems	☐ Thyroid problems	☐ Skin diseases
☐ Stroke	☐ Cancer: type_____	☐ Depression
☐ Diabetes	☐ Infectious diseases/hepatitis	☐ Blood Clots
☐ Low Blood Sugar	☐ Kidney problems	

☐ Other_____

Surgeries/Hospitalizations: Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for surgery or hospitalization:

Date	Surgery/hospitalization	Date	Surgery/hospitalization
_____	_____	_____	_____
_____	_____	_____	_____

Family History: Please check if anyone in your immediate family (brothers, sisters, parents) has ever been treated for the following:

☐ Diabetes	☐ Depression	☐ Cancer: Type_____
☐ Heart Disease	☐ Stroke	☐ Alcoholism (chemical dependency)
☐ High Blood Pressure	☐ Kidney Disease	☐ Inflammatory Arthritis (Rheumatoid, Ankylosing)

Medications: Which of the following medications have you taken in the last week?

	Physician Prescribed	Not Prescribed by Physician
Aspirin	☐	☐
Tylenol	☐	☐
Anti-inflammatories(Advil/Ibuprofen)	☐	☐
Vitamins/mineral supplements	☐	☐
Herbals/Remedies	☐	☐

Others NOT prescribed by Physician_____

Please list any other physician-prescribed medication you are currently taking (INCLUDING pills, injection, and/or skin patches):

1._____ 3. _____ 5._____

2. _____ 4. _____ 6. _____

Symptoms: Please check if you have experienced any of the following in the past 6 months:

_____Urinary Leakage: Date of onset_____

- **Surgeries/interventions: (Please indicate date)** ☐ none
  _____Robotic prostatectomy _____Radical prostatectomy
  _____radiation therapy _____ TURP
  Other(please describe)_____
- **Complications after these procedures:**_____
- **Type of pad used:** ☐ none ☐ undergarment ☐ guards or similar ☐ toilet tissue/paper towel ☐ use clamp
- **Number used per day:** _____undergarment _____guards or similiar
  Per Night: _____undergarment _____guards or similar

- **Activity increasing leakage:** ☐ vigorous ☐ light ☐ change in position (e.g. sit to stand) ☐ bending ☐ cough, sneeze, laugh ☐ lifting ☐ exercise ☐hearing running water ☐ arriving home ☐ walking to the bathroom ☐ leakage at rest ☐ unable to feel leakage when it occurs
- **Urgency:** ☐ strong urge causes leakage ☐ able to control urgency ☐ not aware of urgency/bladder fullness
- **Pattern:** ☐ leakage increases as day progresses ☐ worse in the morning ☐ little/none at night ☐ no pattern
- **Medications:** ☐ Ditropan ☐ Vesicare ☐ Detrol ☐ Enablex
  ☐ Other (indicate medication)_____
- **Urinary Frequency:** _____times per day _____ times per night

_____**Urinary Retention/difficulty emptying bladder/incomplete emptying:** Date of onset_____

_____**Fecal Leakage: Date of onset**_____

- **Type of pad used:** ☐ none ☐ undergarment ☐ guards or similar ☐toilet tissue/paper towel
- **Frequency of leakage:** (indicate number) ___times per day ___times per week___per month
- **Number used per day:**_____undergarment _____guards or similar _____

Per night:_____undergarment _____guards or similar

- **Activity increasing leakage:** ☐ vigorous ☐ light ☐ change in position (e.g. sit to stand) ☐ bending ☐ lifting ☐ cough/sneeze/laugh ☐ exercise ☐ leakage happens at rest ☐ oozing after BM ☐ unable to feel leakage occurring
- **Consistency of stool:** ☐ hard ☐ soft ☐oozing/staining
- **Medications taken for this:**_____

_____**Constipation: Date of onset**_____

- **Frequency of bowel movement (indicate number)** _____per day ____per week ____per month
- **Pain with bowel movement:** ☐ yes ☐ no
- **Consistency of stool:** ☐hard ☐ soft
- **Medications/supplements:** ☐ Miralax/Dulcolax ☐ Metamucil ☐ Citrucel ☐ Senna ☐ Stool softener/colace ☐ other_____

_____**Pelvic Pain: Date of onset**_____

- **Urinary Frequency:** _____times per day _____times per night
- **Location:** ☐ abdomen ☐ scrotum ☐

INNER CIRCLE PHYSICAL THERAPY & MYOFASCIAL RELEASE CENTERS

Timothy M. Alloway M.S.P.T.

AUTHORIZATION TO PAY, TREAT, AND RELEASE INFORMATION

I hereby authorize payment directly from Medicare, any insurance company, any other third party payer (if you are doing self pay), state medical agency, or any other government or private payer to the above Physical Therapy office of the surgical and/or medical and/or physical therapy and rehabilitation benefits, if any, otherwise payable to me, for their services. Further, I understand that billing Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, or any other government or private payer is a courtesy by this authorization. Furthermore, I voluntarily consent and agree to receive physical therapy treatment administered by Inner Circle Physical Therapy and Rehabilitation

I also authorize Inner Circle Physical Therapy and Rehabilitation to release any medical information about me to Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, or any other government or private payer responsible for paying such benefits. I authorize a copy of this authorization to be used in place of the original. I also am aware of Inner Circle Physical Therapy's privacy practices and understand that Inner Circle Physical Therapy and Rehabilitation will not sell my personal information to any company however I do agree to receive marketing media from Inner Circle Physical Therapy and Rehabilitation.

I understand Inner Circle Physical Therapy and Rehabilitation follows the rules and regulations set forth by each insurance carrier. Therefore, I understand I am responsible for my copayment at the time of service. I also understand should I not have any heath insurance that is accepted at Inner Circle Physical Therapy and Rehabilitation, I will be responsible for payment for all services provided to me. I also understand that only cash, checks or credit cards are acceptable forms of payment for any copays, coinsurances or deductibles.

_____ _____

Date Signature of Patient, or Parent if Minor

Insurance Verification Policy

As a courtesy to our patients, Inner Circle Rehabilitation performs third-party verification of insurance plans to determine eligibility, coverage and benefits pertaining to physical therapy/rehabilitative services. Although it is our intention to obtain accurate information from your insurance company regarding your benefits, this is not always possible. Please understand that we have received incorrect information in the past; therefor once your insurance company processes your claim any difference in patient responsibility will be your responsibility to reimburse Inner Circle Rehabilitation as indicated by your insurance company.

You can assist in avoiding this by being informed as to your benefits (i.e. deductibles, copays, co-insurance, etc.) for specialists. Be aware that if you are currently under the care of other rehabilitation specialists; including, but not limited to physical therapists, chiropractors, occupational and/or speech therapists, your insurance company will abide by the following rules:

- The insurance company will only reimburse for one rehabilitation specialty per day; therefore, multiple claims from separate rehabilitation specialists are reimbursed on a first-come, first-served basis with all others being denied. If Inner Circle Rehabilitation is the facility that is denied, you will be responsible for that visit at self-pay rates. To avoid this issue, do not schedule appointments with other rehabilitation facilities on the same day as your appointment with Inner Circle Rehabilitation.
- Similarly, if you are attending any of these services in the same time period, your insurance company applies them to the same category. Therefore, if your benefits have limitations on number of visits, reimbursement caps, etc., the number of visits available at Inner Circle Rehabilitation will decrease.

Thank you for your cooperation in this matter.

Please sign below to acknowledge you have read and understand this policy.

_____ _____

Signature of Patient (signature of parent if minor) Date

Inner Circle Rehabilitation

Cancellation / No Show Policy

It is the policy of this office to request patients to give 24 business hours notice if you are unable to keep your scheduled appointment.

Missed appointments with no phone call to our office are referred to as "no show". No show appointments will be documented in the patient's chart. No show appointments will be charged a fee for each no show visit. Your physician will also be informed of your lack of attendance.

The following fee will be charged based upon your type of appointment:

- **Regular appointment - there will be a $25.00 charge for each cancelled appointment with less than 24 business hours notice after the second occurrence. A no show will have an automatic charge of $25.00 on the first occurrence.**

- **Intensive appointment - there will be a $70.00 charge for each cancelled appointment with less than 24 business hours notice after the first occurrence. A no show is an automatic charge of $70.00 on the first occurrence.**

  Intensive appointment- 30 minute session. There will be a $50.00 charge for each cancelled appointment with less then 24 hour business notice after the first occurrence. A no show is an automatic charge of $50.00 on the first occurrence.

This fee must be paid at your next appointment before treatment will be rendered. Insurance companies do not cover this fee.

By notifying us prior to 24 business hours that you are unable to keep your appointment, we will be able to offer this appointment time to another patient that is in need.

Thank you for your cooperation in this matter.

Please sign below to acknowledge you have read and understand this policy.

_____ _____

Signature of Patient (signature of parent if minor) Date

INNER CIRCLE CONSULTING, INC.
PHYSICAL THERAPY AND REHABILITATION

INFORMED CONSENT
for
ASSESSMENT AND TREATMENT OF THE PELVIC FLOOR

Internal examination of the pelvic floor muscles is consistent with physical therapy practice. It complies with national physical therapy policies requiring the performance of test and measurements of neuromuscular function as an aid to the evaluation and treatment of a specific medical condition.

- this statement was adopted by the executive committee of the Section on Obstetrics and Gynecology of the American Physical Therapy Association.

I understand that it may be beneficial for my therapist to perform soft tissue assessment and treatment of the pelvic floor. Palpation of this area is most direct and accessible if done via the vagina and/or rectum. Pelvic floor dysfunctions include pelvic pain, urinary or fecal incontinence, dyspareunia (pain with intercourse), pain from episiotomy or scarring, vulvodynia, vestibulitis, or other similar conditions. Restrictions in this area may also be contributing to symptoms in other area of the body.

I understand that the benefits of this procedure will be explained to me. I understand that, if I am uncomfortable with participating in this treatment procedure AT ANY TIME, I will inform the therapist and the procedure will be discontinued and alternatives will be discussed with me.

This direct pelvic floor release procedure utilizes Myofascial Release principles entailing the relaxation and lengthening of muscles, fascia and other soft tissue structures within the areas of the pelvic floor, sacrum, coccyx, and the sacroiliac, hip and pubic joints. The procedure also requires pressure and/or distraction directly to the coccyx bone. This technique is an accepted physical therapy technique, as indicated above. Our experience has demonstrated that this direct pelvic floor release is helpful, often facilitating consistent therapeutic results. As with any area of the body, most people require a series of these specific treatments. This is determined by evaluation and treatment findings.

It is my consent that I have informed the therapist of any of the following conditions: that if I am pregnant, have infections of any kind, have vaginal dryness, are less than 6 weeks post partum or post surgery, have severe pelvic pain, using any IUD, sensitivity to KY jelly, vaginal creams or latex.

I have read and understand fully and consent to the above procedure being performed by the therapists at Inner Circle Consulting, Inc.

_____ _____

Date Signature of Insured Person

_____ _____

Date Patient's Printed Name

Inner Circle Physical Therapy & Myofascial Release Centers

1262 Wood Ln Suite 205
Langhorne PA 19047
215-860-3623
Fax 215-860-3763

"THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY."

This notice is provided in pursuant to the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPPA"). It is designed to tell you how we may, under federal law, use or disclose your Health Information.

We may use or disclose your health information for purposes of treatment, Payment or Healthcare operations without obtaining your prior authorization and here is one example of each:

We may provide your healthcare information to other healthcare professionals – including doctors, nurses, and technicians – for purposes of providing you with care.

Our billing department may access your information – and send relevant parts – to other insurance companies to allow us to be paid for the services we render to you.

We may access or send your information to out attorneys or accountants in the event we need the information in order to address one of our own business functions.

We may send you marketing media from Inner Circle however we will not sell your personal information to any company.

We may also use or disclose your healthcare information under the following circumstances without obtaining your prior authorization:

To notify and/or communicate with your family. Unless you tell us you object, we may use or disclose your health information in order to notify your family or assist in notifying your family, your personal representative or another person responsible for you care about your location, your general condition or in the event of your death. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in any communications with your family and others, As Required by Law.

For Public Health Purposes. We may use or disclose your health information to provide information to state or federal public health authorities, as required by law to prevent or control disease, injury or disability; to report child abuse or neglect; report domestic violence; report to the Food and Drug Administration problems with products and reactions to medications; and report disease or infection exposure.

For Health Oversight Activities. We may use or disclose your health information to health oversight agencies during the course of audits, investigations, certification and other proceedings.

In response to Civil Subpoenas or Judicial and Administrative Proceedings. We may use or disclose your health information, as directed, in the course of any civil administrative or judicial proceeding. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your health information prior to another person.

To Law Enforcement Personnel. We may use or disclose your health information to a law enforcement official to identify or locate a suspect, fugitive, material witness or missing person, comply with a court order or grand jury subpoena and other law enforcement purposes.

To Coroners or Funeral Directors. We may use or disclose your health information for purpose of communicating with coroners, medical examiners and funeral directors.

For Purposes of Organ Donation. We may disclose your health information for purposes of communicating to organizations involved in procuring, banking, or transplanting organs or tissues.

For Public Safety. We may use or disclose your health information in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

To Aid Specialized Government Functions. If necessary we may use or disclose your health information for military or national security purposes.

For Worker's Compensation. We may use or disclose your health information as necessary to comply with the worker's compensation laws.

To Correctional Institutions or Law Enforcement Officials, if you are an inmate

For all other circumstances we may only use or disclose your health information after you have signed an authorization. You have the right to revoke this authorization to use or disclose your health information at any time, provided that the revocation is in writing, except to the extent that we have already taken action in reliance upon your authorization.

State Law Impact. To the extent that state law is more restrictive with respect to our ability to use or disclose your health information, or to the extent that it affords you greater rights with the respect to the control of your health information, we will follow state law. This may arise if your health information contains information relating to HIV/AIDS, mental health, alcohol and/or substance abuse, genetic testing, among others.

You should be advised that we may also use or disclose your health information for the following purposes:

Appointment reminders. We may use your health information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.

Change of ownership. In the event that our Practice is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Rights.

1. You have the right to request restrictions on the uses and disclosures of your health information. However, we are not required to comply with your request.
2. You have the right to receive your health information through confidential means through reasonable alternative means or at an alternative location.

3. You have the right to inspect and copy your health information. We may charge you a reasonable cost-based fee to cover copying, postage and/or preparation of a summary.
4. You have a right to request that we amend your health information that is incorrect or incomplete. We are not required to change your health information and will provide you with information about our denial and how you can disagree with the denial.
5. You have the right to receive an accounting of disclosures of your health information made by us, except that we do not have to account for disclosures authorized by you; made for treatment, payment, health care operations; provided to you; provided in responses to an authorization; made in order to notify and communicate with family; and/or for certain government functions, to name a few.
6. You have the right to a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise more of these rights, contact us using the information provided below.

Our Duties
We are required by law to maintain the privacy of your health information and to provide you with a copy of this notice.
We are required to abide by the terms of this Notice.
We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your health information – even if it was created prior to the change in the Notice. If such amendment is made, we will immediately display the revised Notice at our office. We will provide you with another copy, of this Notice at any time, upon request.

Complaints to the Government.
You may make complaints to the Secretary of the Department of Health and Human Services ("DHHS") if you believe your rights have been violated.
We promise not to retaliate against you for any complaint you make to the government about our privacy practices.

Contact Information.
You may contact us about our privacy practices by writing or calling the Privacy Officer at:

Inner Circle Physical Therapy
1262 Wood Ln Ste 205
Langhorne PA 19047
Telephone: 215-860-3623
Fax: 215-860-3763

You may contact the DHHS at:
200 Independence Avenue, S.W.
Washington, D.C. 20201
Telephone: 202-619-0257
Toll Free: 1-877-696-6775

Electronic Notice.
Currently electronic notice is unavailable at Inner Circle Consulting Inc.

_____ _____
Date Signature of Insured Patient

_____ _____
Date Print Your Name

_____ _____
Date Signature of Parent if Minor