Orthopedic & Spine Center
Theraplay LLC

Bloomington Orthopedic & Spine Center
Theraplay LLC
4651 W Vernal Pike
Bloomington, IN 47404
Telephone: (812) 332-7529 Fax: (812) 339-752

Patient Information

Date: _____ Date of Birth:_____ Age: _____

First name:_____ Middle: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

SSN: _____ Sex: ☐ Male ☐ Female ☐ Nonbinary Occupation:_____

REMINDER: ☐ Email ☐ Phone ☐ Text/Provider_____

Cell: _____ Home: _____ Email Address: _____

Are you willing to receive electronic billing statements from Theraplay LLC? ☐ Yes ☐ No

Emergency Contact Name: _____ Phone: _____

Relationship to patient: _____

Health History

Primary Care Doctor: _____ Referral Doctor: _____

Date of next doctor's appointment: _____

Please Mark ALL that apply:

High Blood Pressure ___
Heart/Circulation Disorder___
Stroke___
Chest pain/discomfort___
fatigue/energy loss___
Diabetes___
Headaches___
Seizures___
Dizzy Spells___
Anemia___
Cancer: Type(or history of)_____

Kidney Disease___
Hepatitis/HIV/AIDS___
Sexually transmitted disease____
Immune deficiency disease_____
Irritable Bowel Syndrome___
Tuberculosis___
hernia/or repairs___
Loss of Bladder/bowel___
Arthritis____
Fibromyalgia____
osteoporosis(penia)___

Subluxated/Dislocated joints___
Slipped/ruptured disc___
Scoliosis___
Painful grinding___
sprains/strains joints___
Broken bones___
Low back pain___
Neck pain___
Falls___
Limited range of motion__
Ankle swelling___
Others: _____

Surgical History:

Y/N Back/spine
Y/N Bones/joints
Y/N Female organs
Y/N Bladder
Y/N Abdominal organs
Others:_____

Current Symptoms:

1) Describe current problem: _____
2) When did your problem first begin? _____
3) Activities that cause or aggravate symptoms: _____
4) What relieves your symptoms? _____
5) If pain present, rate level of pain (0 = no pain, 10 = worst imaginable pain): _____
6) Rate severity of this problem from 0-10 (0 = no problem, 10 = being the worse): _____

What are your treatment goals/concerns?

_____

_____

OB/GYN History:

Y/N Childbirth vaginal deliveries #___
Y/N Episiotomy # ____
Y/N C-section # ____
Y/N Difficult childbirth # ____
Y/N Prolapse or organ falling out
Y/N Vaginal dryness
Y/N Painful periods
Y/N Menopause - when? _____
Y/N Painful vaginal penetration
Y/N Pelvic pain

Pelvic Symptoms:

1) Frequency of urination: awake hours_____ times per day, sleep hours_____ times per night
2) The usual amount of urine passed is ____ small ____ medium ____ large.
3) Frequency of bowel movements _____ times per day, ____ times per week. Or _____
4) Constipation or straining? Y/N
5) Average fluid intake (1 glass = 8 oz or 1 cup) _____ glasses per day
6) Rate a feeling or organ "falling out"/prolapse or pelvic heaviness/pressure
   ___ none present
   ___ times per month (specify if related to activity or period)
   ___ with standing for ____ minutes or _____ hours.
   ___ with exertion or straining
   ___ other

Skip questions if no leakage/incontinence present:

7) Bladder leakage - number of episodes
   __ no leakage
   __ Times per day
   __ Times per week
   __ Times per month
   __ Only with physical exertion/cough

8) On average, how much urine do you leak?
   __ No leakage
   __ Just a few drops
   __ Wets underwear
   __ Wets outerwear

9) Bowel leakage - number of episodes
   __ no leakage
   __ Times per day
   __ Times per week
   __ Times per month
   __ Only with physical exertion/cough

10) How much stool do you lose?
   __ No leakage
   __ Stool staining
   __ Small amount in underwear
   __ Complete emptying

11) What form of protection do you wear? (Please complete only one)

___ None
___ Minimal protection (tissue paper/paper towel/panty liner)
___ Moderate protection (absorbent products, maxipads)
___ Maximum protection (Specialty product/diaper)
___ Other _____

On average, how many pad/protection changes are required in 24 hours? ____ # of pads

Please continue for consent/signatures →

Pelvic Floor Internal Exam Consent: During the physical therapy evaluation for the problems you report, an evaluation of your pelvic floor muscles for strength, resting tone (tightness), and coordination (contract/relax) may be performed to gain further valuable information to aid with your assessment and creation of an appropriate treatment plan for your symptoms. Your evaluation may include an internal assessment of the pelvic floor muscles which will be completed vaginally. Your physical therapist will discuss this option and receive your consent before initiating this exam as well as discuss the findings with you. You can say no or refuse any, or all, of the exam at any time of the assessment. The assessment may result in soreness or discomfort temporarily. If this occurs, please discuss it with your physical therapist.

We understand some patients may be apprehensive because of the private nature of the condition and the examination. Please ask as many questions as you need for your comfort and understanding of the exam, findings, and treatment. Discuss any concerns or hesitation you may have with your physical therapist.

By signing this form, you agree and understand that treatment as indicated above may be necessary for effective treatment of your problem, and you agree that we have permission to treat as discussed. You are always free to change your mind at any time during your course of treatment. You also have the option to have a second person in the room for your pelvic floor muscle evaluation and treatment. The second person can be a friend, family member, or clinic staff member. Please indicate your preference with your initials:

____ **YES,** I want a second person present during the pelvic floor muscle evaluation and treatment

____ **NO,** I do not want a second person during the pelvic floor muscle evaluation and treatment

____ I would like to discuss my options with my PT prior to consenting.

Consent: I have read and understand the Informed Consent for pelvic floor muscle evaluation, and I consent to the evaluation and treatment, unless otherwise noted below.

_____

(Please list any exception to consent - if none, write none)

Signature: _____ **Date:** _____

CONSENT TO TREAT: I, hereby request and consent to THERAPLAY LLC to perform rehabilitative treatment and care as prescribed by my physician and/or recommended by my physical therapist. I understand and am informed that, as in the practice of physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions answered about my condition, prior to treatment. I authorize the physical therapist to perform any additional or different treatment, which is deemed necessary should, during treatment, a condition be discovered which was not known previously. I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss my condition with the treating physical therapist. I consent and authorize THERAPLAY LLC (including students in training) to administer treatment under the direction and supervision of the Physical Therapist.

By signing below, I acknowledge the above consent and indicate my agreement with the prescribed PHYSICAL THERAPY program discussed with my Physical Therapist.

Signature of Patient or Legal Guardian: _____ Date: ____/____/_____

NO SHOW AND LATE CANCELLATION POLICY: Appointments not canceled 24 hours prior to scheduled appointment time and no show appointments will be assessed a fee of $25.00. These charges are the patient's responsibility and will be billed directly to them. Following 3 no shows/late cancellations, any further appointments will be removed from the schedule.

I acknowledge I am aware of the no show and late cancellation policy and will be responsible for any fees assessed for this policy.

Signature of Patient or Legal Guardian: _____ Date: ____/____/_____

ASSIGNMENT & RELEASE: I, assigned Theraplay LLC, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. In the event that my account is referred to a collection agency or an attorney, I further agree to pay all reasonable costs incurred to collect any amounts that are due and owing for services rendered by Provider including, without limitation, reasonable attorney's fees.

I hereby authorize Theraplay LLC, to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission whether manual or electronic.

Signature of Patient or Legal Guardian: _____ Date: ____/____/_____

NOTICE OF PRIVACY PRACTICE: I understand that, under the Health Insurance Portability & Accountability Act ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand (or have been given the option) your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I chose not to obtain a copy of this organization's Notice of Privacy Practices but I am aware of my right to do so at any time.

Signature of Patient or Legal Guardian: _____ Date: ____/____/_____