

# Action Potential

One on One Physical Therapy

\_\_\_\_\_  
Client Name/DOB

\_\_\_\_\_  
Preferred Pronoun (he, she, they)

\_\_\_\_\_  
Doctor

\_\_\_\_\_  
Date of Last Pelvic Exam, if applicable

### Current Pelvic Issue:

- Incontinence     
  Pelvic Pain     
  Prolapse     
  Other

Rate your current issue: No Problem 0 1 2 3 4 5 6 7 8 9 10 Severe Issue

### Pelvic History:

- |   |   |
|---|---|
| <input type="checkbox"/> Vaginal Deliveries(#): _____     | <input type="checkbox"/> Cesarean Deliveries(#): _____        |
| <input type="checkbox"/> Episiotomies (#): _____          | <input type="checkbox"/> Difficult Labor: _____               |
| <input type="checkbox"/> Prolapse: Type: _____            | <input type="checkbox"/> Vaginal Dryness: _____               |
| <input type="checkbox"/> Painful Periods                  | <input type="checkbox"/> Menopause Onset: _____               |
| <input type="checkbox"/> Painful Sex/Penetration          | <input type="checkbox"/> Pelvic/ Low Back/Scrotal/Penile Pain |
| <input type="checkbox"/> Prostate Cancer/Surgery/Enlarged | <input type="checkbox"/> Abdominal/Pelvic Surgery             |
| <input type="checkbox"/> Pelvic Injuries/Trauma           | <input type="checkbox"/> Erectile Dysfunction                 |
| <input type="checkbox"/> Food Sensitivities               | <input type="checkbox"/> GI disorders                         |

### Bladder/Bowel Habits:

- |  |   |
|--|---|
| <input type="checkbox"/> Trouble initiating urine stream       | <input type="checkbox"/> Urgency of bowel or bladder  |
| <input type="checkbox"/> Trouble emptying bladder              | <input type="checkbox"/> Hemorrhoids/Anal Fissures    |
| <input type="checkbox"/> Straining/Pushing to empty bladder    | <input type="checkbox"/> Urine leakage                |
| <input type="checkbox"/> Blood in urine                        | <input type="checkbox"/> Painful urination            |
| <input type="checkbox"/> Trouble feeling bladder urge/fullness | <input type="checkbox"/> Constipation/Bowel straining |
| <input type="checkbox"/> Trouble feeling bowel urge/fullness   | <input type="checkbox"/> Trouble holding gas/feces    |
| <input type="checkbox"/> Nighttime urination(#): _____         | <input type="checkbox"/> Other: _____                 |

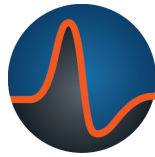
### Consent to Treatment

\_\_\_\_\_(initial) I consent to internal pelvic evaluation/treatment by the therapists at Action Potential

\_\_\_\_\_(initial) I require a second person be present during all internal pelvic treatments

**Client Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



# Action Potential

One on One Physical Therapy

Client Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Referring Physician \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Email \_\_\_\_\_

Identified Gender: Male / Female / Other

### Past Medical History:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Alzheimer's               | <input type="checkbox"/> Fibromyalgia             | <input type="checkbox"/> Parkinson's          |
| <input type="checkbox"/> Cardiovascular Disease    | <input type="checkbox"/> Fracture                 | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Coronary Artery Bypass    | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Brain Injury         |
| <input type="checkbox"/> Heart Attack              | <input type="checkbox"/> History of Cancer        | <input type="checkbox"/> COPD/Emphysema       |
| <input type="checkbox"/> Pacemaker                 | <input type="checkbox"/> Huntington's             | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Cauda Equina Syndrome     | <input type="checkbox"/> Immunosuppression        | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Stroke/TIA                | <input type="checkbox"/> Lupus                    | <input type="checkbox"/> Cataracts            |
| <input type="checkbox"/> Current Infection         | <input type="checkbox"/> Muscular Dystrophy       | <input type="checkbox"/> Amputation           |
| <input type="checkbox"/> Diabetes Mellitus Type I  | <input type="checkbox"/> Obesity                  | <input type="checkbox"/> Anxiety              |
| <input type="checkbox"/> Diabetes Mellitus Type II | <input type="checkbox"/> Osteoarthritis           | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> Diabetic Neuropathy       | <input type="checkbox"/> Pelvic Pain/Incontinence |   |

Other: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Recent Falls: YES NO Explain: \_\_\_\_\_

At the present time would you say that your health is:

- excellent     very good     fair     poor

Please rate your current pain:

0      1      2      3      4      5      6      7      8      9      10

No pain

Severe pain

therapist initial: \_\_\_\_\_ date: \_\_\_\_\_



**Medication List:** Please list all prescription and over the counter medications, vitamins, supplements. Include dose, frequency, and route  
*If you already have a current list, we are happy to make a photocopy*

Name	Dose	Frequency	Route (oral, injection, etc.)

therapist initial: \_\_\_\_\_ date: \_\_\_\_\_

## Acknowledgement of Receipt of Privacy Notice

### Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

**Please read the following information carefully:**

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Action Potential, LLC (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.
2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.
3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: Attn: Compliance Officer, Action Potential, 1786 Wilmington Pike, Suite 200A, Glen Mills, PA, 19342.
4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

\_\_\_\_\_

5. I authorize the Practice, to disclose my health information that is directly related to my current treatment to the individual(s) listed below:

\_\_\_\_\_  
Name of Individual(s)

\_\_\_\_\_  
Relationship to Client

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

**BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.**

\_\_\_\_\_  
Signature of Client or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client's Printed Name

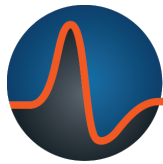
\_\_\_\_\_  
Client's Date of Birth

\_\_\_\_\_  
Printed Name of Representative (if applicable)

\_\_\_\_\_  
Relationship to Client

### Scheduling Availability: Please cross out any times that you are unavailable for appointments

Monday	Tuesday	Wednesday	Thursday	Friday
Morning	Morning	Morning	Morning	Morning
Afternoon	Afternoon	Afternoon	Afternoon	Afternoon
Evening	Evening	Evening	Evening	Evening



# Action Potential

One on One Physical Therapy

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## **Statement of Patient Financial Responsibility**

Action Potential, LLC, is pleased to be your specialized physical therapy provider. The services you have elected to receive imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your primary insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill. You are responsible to notify Action Potential, LLC of any changes to your insurance plan.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. These payments are due at the time of service. You are also responsible for any amount not covered by your insurance carrier. If your insurance carrier (including Workers Compensation and Motor Vehicle) denies any part of your claim, or if you elect to continue services past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Action Potential, LLC and I authorize my insurer to pay the full and entire amount of the bill for the above-mentioned patient. I will assume responsibility for any remaining balance.

\_\_\_\_ (initial) Your co-payment amount: \_\_\_\_\_

## **Office Policies**

\_\_\_\_ (initial) There will be a **\$25.00** penalty assessed for any returned check.

\_\_\_\_ (initial) We request 24 business hours notice for all cancellations due to our one to one policy. Cancellations made in less than requested time allotment will result in a **\$50.00** charge.

## **Consent to Treatment**

\_\_\_\_ (initial) I hereby consent to evaluation and treatment by the therapists at Action Potential, LLC.

\_\_\_\_ (initial) I consent that information regarding my care may be communicated via voicemail/text and/or email.

\_\_\_\_ (initial) I consent to being photographed or video taped for the purpose of patient education, instruction, and development of a home exercise program. I am aware that media specific to my plan of care will be placed in my medical record as protected health information and only disclosed to me. Media will not be disclosed further without my consent.

\_\_\_\_ (initial) I give my permission and would like to be contacted about continued after care programs.

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Client Representative: \_\_\_\_\_

Date: \_\_\_\_\_

(If patient is a minor, or if authorized by patient)