IN BALANCE PHYSICAL THERAPY & PELVIC HEALTH

21 Crossroads Drive Ste 210 Owings Mills, MD 21117
Ph (443) 948-6609 Fax (443) 948-6610

PATIENT REGISTRATION FORM

First Name: _____ Last Name: _____ MI: _____
Date of Birth: _____ Age: _____ Marital Status: _____

Occupation: _____

Street Address: _____
City: _____ State: _____ Zip Code: _____

E-mail Address: _____

Home Phone: _____ Cell phone: _____
Cell phone carrier: _____ Reminder calls: (circle: text/email)

Emergency Contact _____ Phone: _____ Relationship: _____

Family Physician: _____ (City, State):_____

Referring Physician: _____ (City, State):_____

OB/GYN (if applicable): _____ (City, State): _____

How did you find our office? (check all that apply) ☐ Doctor Referral ☐ Friend/Family Member
☐ Insurance Company ☐ Internet Search ☐ Other (please explain): _____

Policy Acknowledgements : My signature below serves as my confirmation of having read and understood the following policies: (Please check)

☐ Condition and Consent for Evaluation and Treatment
☐ HIPAA Notification
☐ Financial Policy

NAME: _____ Date: _____

Signature: _____Guardian (if applicable) _____

IN BALANCE PHYSICAL THERAPY & PELVIC HEALTH

CANCELLATION POLICY

Welcome to our clinic. We are so happy to be able to help you with your pelvic health concerns. Our skilled therapists have had specialized and advanced training to assist you through your recovery process. We pride ourselves in spending one-on-one, quality time with each of you while still accepting most insurance plans. If we can ever be of further assistance please don't hesitate to talk with us. We feel fortunate to take this journey to recovery with you.

This letter is to inform you of our cancellation/reschedule policy.

We require a minimum of 24 hour notice if you cannot keep a scheduled appointment. If you cancel less than 24hours before your appointment, or miss the appointment all together, there will be a charge of $50. This fee is due at your next visit before you can be seen for additional treatment. If you are able to reschedule your appointment within the same week, we will waive the cancellation fee for that visit. If there are no available appointment times for the appointment to be rescheduled, then the fee will not be waived. Appointments scheduled for a Monday, must be cancelled by the close of business day on Friday (2:00pm). Appointments must be cancelled via email to info@inbalancephysicaltherapy.com or 443-948-6609

This charge is to cover expenses incurred by our office because of your missed appointment. Due to our specialized services, we have a long waiting list for patients to be seen. Your missed appointment would have given another patient the opportunity to be treated.

The cost of the cancellation fee is owed by you, and cannot be billed to your insurance company. Bills are mailed out every 30 days. Failure to pay unpaid balances will result in a $15 late fee per month.

In the event that we are able to fill your appointment with another patient, the fee will be waived on a case-by-case basis.

IBPT strives to provide each patient with the highest quality of care while attempting to accommodate your schedule. Your consistent attendance of the planned treatment regimen is paramount to your full recovery. We thank you so much for your cooperation in this matter!

I understand that in the event that I must cancel or miss my appointment, I am responsible for contacting In Balance Physical Therapy within 24 hours of that visit.

_____ _____

Signature of patient Date

CONSENT

Condition and Consent for Evaluation and Treatment of Pelvic Floor Dysfunction

I acknowledge and understand that I have been referred to In Balance Physical Therapy & Pelvic Health, LLC for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include but are not limited to urinary or fecal incontinence, difficulty with bowel, bladder or sexual functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, and vulva, rectal or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function of the pelvic floor region. I understand that this evaluation and/or treatment could potentially elicit pain or discomfort. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

Your physical therapist is female. No chaperone will be provided during your physical therapy evaluation and treatment sessions unless you request a chaperone to be present. You may choose to bring a friend or family member during the physical therapy evaluation or treatment at any time.

Treatment may include, but not be limited to the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

I understand that no guarantees have been or can be provided regarding the success of therapy. I have informed my therapist of any condition that would limit my ability to have an 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 In Balance Physical Therapy & Pelvic Health, LLC.

Conditions:

In order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

Patient Signature : _____ Date: _____

Patient Name (Please Print) :_____

Signature of Parent or Guardian (If applicable):_____

ASSIGNMENT OF BENEFITS

By signing below you are verifying your consent to allow your insurance carrier to make payments directly to In Balance Physical Therapy at 21 Crossroads Drive, Ste 210, Owings Mills, MD 21117 for all services rendered at the same location. You are also confirming that you have are aware that the verification of benefits is not a guarantee of payment by your insurance carrier and any claims unpaid by your insurance become your responsibility.

Patient's Signature : _____ Date_____

PAST MEDICAL HISTORY

REASON FOR YOUR VISIT TODAY:

_____

_____

ALLERGIES (MEDICATION/FOOD, INDICATE REACTION): ☐ NONE

_____

_____

MEDICATION LIST: (PLEASE LIST NAME/DOSE/FREQUENCY IF KNOWN)

_____

_____

Habits:

Alcohol: No Yes: How many drinks/day _____ frequency/week _____What kind_____
Tobacco: No Yes: Chew or smoke?_____ How many/day _____ since_____
Caffeine: No Yes: What kind_____ How many/day _____
Other Recreational Drugs: No Yes: What kind_____ How many/day _____
Do you drive? No Yes Do you exercise? No Yes Type: _____

Which of the following most accurately describes you? (choose as many as you like)

Female/Male/Non Binary/Transgender/Intersex or I would prefer not to say Other: _____

Sexual preference: Men Women Both Neither
Are you sexually active? Y N

History of sexual abuse? Yes No
If No, would you like to be sexually active? Yes No

Children (age):_____
Hobbies:_____

PAST SURGICAL HISTORY

☐ None ☐ Coronary Bypass ☐ Cardiac Stents ☐ Pacemaker ☐ Heart Valve ☐ Gall Bladder ☐ Appendectomy
☐ Bowel/Stomach Resection ☐ Hemorrhoidectomy ☐ Bariatric surgery ☐ Hysterectomy ☐ Hernia ☐ Spinal Surgery
☐ Tubal Ligation ☐ Bladder surgery ☐ Prostate surgery/resection ☐ C-Section ☐ Orthopedic/joints_____
Other_____

Past Medical History

Stroke	Yes	No	HIV / AIDS	Yes	No
Diabetes (Type 1 or Type 2)	Yes	No	Chronic Wounds	Yes	No
Hearing Loss	Yes	No	Cancer (type) _____	Yes	No
High Blood Pressure	Yes	No	Incontinence	Yes	No
Blood Clots	Yes	No	Kidney Stones	Yes	No
Pulm Emboli (lung clots)	Yes	No	COPD (Emphysema, Bronchitis)	Yes	No
Reflux	Yes	No	Asthma	Yes	No
Heart Disease	Yes	No	Depression	Yes	No
Coronary Disease	Yes	No	Bipolar Disorder	Yes	No
MI/heart attacks	Yes	No	Anxiety	Yes	No
Congestive Heart Failure	Yes	No	Fibromyalgia	Yes	No
Atrial Fibrillation	Yes	No	Chronic Fatigue Syndrome	Yes	No
STD_____	Yes	No	Arthritis	Yes	No
Gastrointestinal Bleeding	Yes	No	Osteoporosis	Yes	No
Hepatitis (A, B, C)	Yes	No	Other_____		

If you are here for issues specifically related to *WOMEN'S HEALTH* please also complete the following:

OB: Are you Pregnant? Y N How many weeks? _____ If yes, when was your last Ob-gyn visit? _____
Number of Pregnancies: ____ Vaginal Deliveries: ___ C-Sections: ___ DandC: ___ Miscarriages: ___ Abortions: ___
Longest Length of pushing: _____ Episiotomies: Yes No Tears: Yes No
Do you have a painful episiotomy scar? Y N Do you have a painful C-section scar? Y N

GYN: Do you experience menstrual pain? Y N Do you have endometriosis? Y N
Have you experienced menopause? Y N Approximate date of onset? _____
Have you been on hormone replacement therapy? Y N If yes, what type? _____

UROLOGY: Do you have a history of frequent UTI? Y N Do you have a history of urine loss as a child? Y N
Do you have a history of urine loss during pregnancy or after childbirth? Y N Do you have Interstitial Cystitis? Y N
Do you have IBS? Y N How many times do you wake up to urinate? _____ How many times do you urinate during the day? ____

If you are here for issues specifically related to *MENS HEALTH* please also complete the following:

Sexual Function:
Do you have any difficulty getting or keeping a firm (hard) erection? Y N
Do you have trouble maintaining a firm (hard) erection to completion of intercourse (i.e. Do you lose your erection too quickly)? Y N
Can you achieve an orgasm? Y N Can you ejaculate normally? Y N
Do you experience pain with erections? Y N Do you experience pain with orgasm? Y N

Prostate:
Have you ever been treated for prostate cancer? Y N Have you had surgery for prostate cancer? Y N
Have you had radiation for prostate cancer? Y N Have you had surgery for benign prostate enlargement? Y N
Are you on androgen deprivation therapy for prostate cancer? Y N What is your most recent PSA level? _____

Urology:
Do you have a history of frequent UTI? Y N Do you have a history of urine loss as a child? Y N
Do you have Interstitial Cystitis (Painful Bladder Syndrome)? Y N How many times do you wake to urinate? _____

HIPAA NOTIFICATION

Notice of Privacy Practices : We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this notice, please contact the Privacy Officer at this practice. If you would like detailed information regarding how we may use and disclose medical information about you and your individual rights regarding your medical information, please let us know and you will be provided with a copy of our Privacy Practices.

Patient Statement : I am aware that this practice, as required by law, maintains the privacy of protected health information as prescribed by HIPAA and that I have access to its provisions. I have been provided an opportunity to review the Notice of Privacy Practices. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in the Notice. I may revoke this authorization at any time in writing.

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

IN BALANCE PHYSICAL THERAPY: FINANCIAL POLICY

We are pleased that you have selected our office to address your pelvic health and orthopedic physical therapy needs. As part of that care, we have developed this statement of our financial policy. Please carefully read the following and then INITIAL in the space provided near each paragraph, and then sign below.

1) _____ Health Insurance Participation: In Balance Physical Therapy participates with many, but not all health insurance plans. If we do participate with your health insurance plan, you must present a valid insurance identification card at check-in. Without a valid insurance card, or if we do not participate in your health insurance plan, you will need to speak with the office manager or owner prior to treatment.

2) _____ Co-Payments/Co-insurance: Some insurance plans require payment of a Co-pay or Co-insurance. Payments are due at check-in. Payments may be made by check, cash, MasterCard or VISA.

3) _____ Referrals: Some insurance plans require a written referral from a primary care provider. Referrals must be presented at check-in. Having a valid referral is a patient's responsibility. It is your responsibility to know how many visits are allowed on your referral and the expiration date of your referral. Without a valid referral if you need one for your insurance, you may reschedule your appointment or payment for your visit will be due upon treatment.

4) _____ Financial Responsibility: Patients are responsible for all co-payments, deductibles, and charges not covered by health insurance.

5) _____ Deductibles: If you have a large deductible ($500/contract year or more) that has not yet been met, you will pay $75.00 per visit up front until you receive your Explanation of Benefits (EOB) from your insurance company. Once your EOB has been sent and the exact amount due is learned, you will be responsible for the remainder of your deductible (if any) at that time. If you have overpaid on your deductible, you will be reimbursed within 7 to 14 days of IBPT receiving your EOB from your insurance company.

6) _____ Account Balances: All outstanding balances must be paid at time of check-in, or if you need, you may set up a payment plan with the office manager or owner. Failure to pay outstanding balances in a timely manner may result in the practice forwarding your account to a Collection Agency or Collection Attorney of our choice and may result in additional fees, including an administrative fee of 30%. Again, you may set up a payment plan with the owner, and this will be set up on an individual basis. You will be given plenty of fair notice prior to any balance being sent to a Collection Agency. Any unpaid balances will be subject to a $15 per month late charge for each month left unpaid.

7) _____ Cancellation: Any cancellation made over the weekend or on a holiday for the very next business day will be subject to a $50.00 cancellation fee.

8) _____ Cancellation/No-Show: You must cancel any appointment with a full 24 hour business days notice on the telephone or via email (jberger@inbalancephysicaltherapy.com) or you are subject to a $50.00 cancellation/No-Show fee.

I (the client of In Balance Physical Therapy) have read and understood the office policies explained above:

Signature: _____ Date: _____

WE ARE GOING "TOUCHLESS"!!

In an effort to follow CDC guidelines and keep our patients and staff as safe as possible, we are moving towards a touchless system therefore, in order to receive treatment, keeping a credit card on file for all incidentals is required.

IN BALANCE PHYSICAL THERAPY
CREDIT CARD AUTHORIZATION NOTICE

By providing us with your credit card and signing this authorization, you authorize In Balance Physical Therapy to charge your credit card for any and all unpaid amounts that In Balance PT or your insurer determines are your responsibility for items and services provided by In Balance PT. You agree that In Balance PT may charge your credit card for such amounts at the end of your current visit or at a later date.

After today's date, In Balance PT will send you itemized bills via U.S mail. Please be sure that your contact information on file with us is correct.

A copy of this authorization is available upon request.

AGREEMENT

I, the undersigned, am an authorized user of the credit card that I supplied you with today. I hereby authorize In Balance PT to charge my credit card for balances due for items and services provided by In Balance PT. I agree to pay all amounts charged pursuant to this authorization in accordance with the issuing bank cardholder agreement.

Credit Card Type: VISA, MC, AMEX, DISCOVER

Name on Card: _____

Credit Card Number: _____ Exp: _____

Billing Zipcode: _____ CCV: _____

_____ _____ _____

Authorized User Signature Printed Name Date

COVID GUIDELINES
PATIENT MEMORANDUM OF UNDERSTANDING AND LIMITATION OF LIABILITY

In light of the ongoing COVID-19 crisis, we need to administer additional steps guided by the Department of Health, CDC, WHO and our governing offices to ensure the wellness and safety of our clients and our staff.

I (patient and/or guardian)_____, understand that the COVID-19 crisis is ongoing and both you and IBPT will take additional steps to ensure the safety of all patients and staff.

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Have you at anytime been diagnosed with COVID-19? Y N Date: _____
2. Within the past 72 hours have you had an elevated temperature above 99.5? Y N
3. Within the past 72 hours have you had any headache or sore throat? Y N
4. Within the past 72 hours have you had any coughing or respiratory issues? Y N
5. Within the past 72 hours have you had vomiting or diarrhea? Y N
6. Have you lost your sense of taste or smell? Y N
7. Have you recently returned from international travel within the past 14 days? Y N
8. Have you been vaccinated for COVID-19 Y N

In the event a scheduled appointment is cancelled for any of the above reasons, the patient's $50 cancellation fee will be waived. In the event of such a waiver, the patient will be required to wait 10 days and be symptom free before they are permitted to schedule their next appointment unless they can provide a physician's note that they are not infected and cleared for treatment or provide a negative PCR COVID test.

We are prohibiting visitors from joining you with the exception of minors and the elderly and handicapped individuals who need assistance in the treatment room. We are no longer having visitors wait in the waiting area.

Please be prepared to have your temperature taken when entering the clinic. Any patient with an elevated temperature above 99.5 will be asked to respectfully leave the office and seek treatment at a later date.

All patients and escorts are required to wear a mask covering their nose and mouth at all times while in the clinic. If you don't have a mask, one will be provided to you.

The In Balance PT team will incorporate all reasonable efforts to keep physical distance between patients. This includes all common areas.

Despite these efforts to prevent the spread of COVID-19, there is no guarantee that the patient will be infected either directly or indirectly through their treatment at IBPT.

You (patient/guardian) _____, expressly waive any and all liability to IBPT in connection with COVID-19 including but not limited to any infection of COVID-19 directly or indirectly related to your treatment at IBPT.

Thank you for choosing our practice in your quest for wellness. We look forward to providing all our patients with the safest experience possible!

PATIENT SIGNATURE: _____

PRINTED NAME: _____ DATE: _____