PATIENT INFORMATION and FINANCIAL POLICY

Thank you for scheduling an appointment for physical therapy! Providing specialized care tailored to your specific needs is our primary goal at By Design Physical Therapy. We are committed to creating a safe space for easy and open communication between both our patients and providers, in order to create a comfortable environment to discuss every patient's health concerns without embarrassment or shame. Our mission is to help patients live their best lives without the struggle of pelvic floor muscle dysfunction.

Here at By Design Physical Therapy, we do not work with insurance companies. This allows us to be less limited by time or quality of treatment provided due to insurance company restrictions or elevate rates to pay billing services. We are considered an out-of-network provider for insurance plans.

Prior to your first scheduled appointment, we recommend you call your insurance company to completely understand your physical therapy benefits. There is an insurance benefits worksheet link posted on the website (www.bydesignpt.com). The worksheet will guide you through the questions to ask when you call your insurance company. Upon request, we can provide you with a superbill/receipt for you to submit to your insurance company for reimbursement if your insurance covers out-of-network physical therapy services. The amount of reimbursement you receive will vary according to the terms of your insurance policy. Some companies may reimburse you at 80%, some at 60%, some at 40%, and some may not reimburse you at all. We cannot make guarantees or estimates regarding what reimbursement your plan allows and we will not work with or communicate with your insurance company.

We are NOT a contracted Medicare provider and at this time, federal law prohibits physical therapists that do not contract with Medicare from treating Medicare Part B recipients, regardless of payment method.
We are also unable to provide physical therapy services to Kaiser Permanente members at this time. However, anyone may receive Reiki services, regardless of insurance provider.

By Design Physical Therapy is a fee-for-service clinic. This means that payment is due at the time services are rendered.
We accept checks, cash (exact amount – no cash is kept on premises) or Visa/MasterCard credit/debit cards, at the time of service. Our fees are based on time spent with you and the treatments performed during your appointment. The fee ranges are as follows:

$200 for initial evaluation/treatment for 60 minutes.
$200 for 50-55 minute Physical Therapy appointments
$150 for 50-55 minute Reiki appointments
$200 for not showing up to scheduled appointments
$50 for cancellations with less than 24 hours notice

We look forward to assisting and working with you.

Sincerely,

Kathy Fry, PT, DPT, OCS
By Design Physical Therapy, Owner

Patient History

Name ____**DOB**___________**Age**___ **Date**__________

1. Describe the current problem that brought you here?____
____

2. When did your problem first begin?____

3. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date ____
____

4. Since that time is it: staying the ___________ same _________ getting worse ________ getting better
Why or how?____

5. If pain is present rate pain on a 0-10 scale 10 being the worst.____________
6. Describe the nature of the pain (i.e. constant burning, intermittent ache)___________________________________
____

7. Describe previous treatment/exercises____
____

8. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

___ Sitting greater than_________ minutes
___ Walking greater than _______minutes
___ Standing greater than ______ minutes
___ Changing positions (ie. - sit to stand)
___ Light activity (light housework)
___ Vigorous activity/exercise (run/weight lift/jump)
___ Sexual activity
___ With cough/sneeze/straining
___ With laughing/yelling
___ With lifting/bending
___ With cold weather
___ With triggers i.e. /key in door
___ With nervousness/anxiety
___ No activity affects the problem
___ Other, please list ____

9. What relieves your symptoms?____
____

10.How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify____
Diet /Fluid intake, specify ____
Physical activity, specify ____
Work, specify ____
Other ____

11. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst ___________

12. What are your treatment goals/concerns?____
____

Since the onset of your current symptoms have you had:

Y/N Fever/Chills
Y/N Unexplained weight change
Y/N Dizziness or fainting
Y/N Change in bowel or bladder functions
Y/N Malaise (unexplained tirednes
Y/N Unexplained muscle weakness
Y/N Night pain/sweats
Y/N Numbness / Tingling
Y/N Other /describe____

Date of Last Physical Exam ___________ Tests performed____
____

Pg 2 History

Name ____DOB ID#______________Age___

General Health: Excellent Good Average Fair Poor Occupation ________________________________
Hours/week__________ On disability or leave?________ Activity Restrictions? ________________________
Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week
Describe ____
Mental Health: Current level of stress High_ Med___ Low___ Current psych therapy? Y/N

Have you ever had any of the following conditions or diagnoses? Circle all that apply

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple sclerosis	Allergies-list below
Ankle swelling	Head Injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/ Hyperthyroid
Low back pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug problem	Arthritic conditions	Kidney disease
Childhood bladder problems	Stress fracture	Irritable Bowel Syndrome
Depression	Acid Reflux /Belching	Hepatitis
Anorexia/bulimia	Joint Replacement	Sexually transmitted disease
Smoking history	Bone Fracture	Physical or Sexual abuse
Vision/eye problems	Sports Injuries	Raynaud's (cold hands and feet)
Hearing loss/problems	TMJ/ neck pain	Pelvic pain

Other/Describe____

Surgical /Procedure History

Y/N Surgery for your back/spine
Y/N Surgery for your brain
Y/N Surgery for your female organs
Y/N Surgery for your bladder/prostate
Y/N Surgery for your bones/joints
Y/N Surgery for your abdominal organs
Other/describe____

Ob/Gyn History (females only)

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/genital pain____________
Y/N Other /describe____

Males only

Y/N Prostate disorders
Y/N Shy bladder
Y/N Erectile dysfunction
Y/N Painful ejaculation
Y/N Pelvic/genital pain location ____
Y/N Other /describe____

Medications - pills, injection, patch	Start date	Reason for taking

Over the counter -vitamins etc	Start date	Reason for taking

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Symptoms

Y/N	Trouble initiating urine stream	Y/N	Blood in stool/feces
Y/N	Urinary intermittent /slow stream	Y/N	Painful bowel movements (BM)
Y/N	Strain or push to empty bladder	Y/N	Trouble feeling bowel urge/fullness
Y/N	Difficulty stopping the urine stream	Y/N	Seepage/loss of BM without awareness
Y/N	Trouble emptying bladder completely	Y/N	Trouble controlling bowel urge
Y/N	Blood in urine	Y/N	Trouble holding back gas/feces
Y/N	Dribbling after urination	Y/N	Trouble emptying bowel completely
Y/N	Constant urine leakage	Y/N	Need to support/touch to complete BM
Y/N	Trouble feeling bladder urge/fullness	Y/N	Staining of underwear after BM
Y/N	Recurrent bladder infections	Y/N	Constipation/straining _____% of time
Y/N	Painful urination	Y/N	Current laxative use -type ____________________________
Y/N	Other/describe ____		

Describe typical position for emptying: ____

1. Frequency of urination: awake hour's _____ times per day, sleep hours _____times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? ________ minutes, _______hours, _________not at all
3. The usual amount of urine passed is: ___small ___ medium___ large
4. Frequency of bowel movements ____ times per day, ________times per week, or ____________.
5. The bowel movements typically are: watery ___ loose ___ formed___ pellets ___ other _______
6. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? ________minutes, ______hours, ________not at all.
7. If constipation is present describe management techniques ______________________________
8. Average fluid intake (one glass is 8 oz or one cup) _________ glasses per day.
   Of this total how many glasses are caffeinated?____ glasses per day.
9. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:

___None present
___Times per month (specify if related to activity or your menstrual period)
___With standing for ___________ minutes or ____________hours.
___With exertion or straining
___Other____

10a. Bladder leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

10b. Bowel leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

11a. On average, how much urine do you leak?
___ No leakage
___ Just a few drops
___ Wets underwear
___ Wets outerwear
___ Wets the floor

11b. How much stool do you lose?
___ No leakage
___ Stool staining
___ Small amount in underwear
___ Complete emptying
___ Other ______________________________

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

___None
___Minimal protection (tissue paper/paper towel/pantishields)
___Moderate protection (absorbent product, maxi pad)
___Maximum protection (specialty product/diaper)
___Other ____

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

CONDITIONS & CONSENT FOR PHYSICAL THERAPY

(Please, initial each item and sign at the bottom)

_____ I understand that I am a patient of Kathy Fry, PT, DPT, OCS who is an independent physical therapy practitioner practicing under By Design Physical Therapy, Inc.

_____**Cooperation with treatment:**
I understand that in order for physical therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

_____**Cancellation Policy**
I understand that if I cancel more than 24 hours in advance, I will not be charged.
I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of $50.00.
If I fail to come to a scheduled appointment without notifying the clinic, I will pay the full amount for the visit ($200).
I also understand that if I arrive late to my scheduled appointment, I will have the remaining time available for that time slot and will be charged the full amount for the visit ($200).

_____**No warranty: I understand that By Design Physical Therapy, Inc. and Kathy Fry, PT, DPT, OCS cannot make any promises or guarantees regarding a cure for or improvement in my condition.** I understand that Kathy Fry, PT, DPT, OCS will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

<u>Informed consent for treatment</u>:
The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

_____**Potential risks:** I understand I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury/symptoms. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

_____**Potential benefits** may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decrease in symptoms, pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

_____**Alternatives:** If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Release of medical records:
_____ I hereby authorize By Design Physical Therapy, Inc. to release all medical records concerning my health care to my physician(s) and/or legal representative(s). Medical information and records may be released by facsimile, telephone, email and/or mail. Please list.

____

NOTIFICATION OF PRIVACY PRACTICES: Acknowledgement of Receipt
We keep a record of the Physical Therapy services that we provide you. You have a right to see, copy, and correct that record. We will not disclose your record to others unless directed to do so by you or an authorized legal authority. Please contact the Privacy Officer for more information.

The Notice of Privacy Practices, mandated by Federal law details your rights regarding your medical information. It requires your signature as an acknowledgment of receipt. Please Pick up our Notice at the front desk when checking in for your first appointment.

_____ I acknowledge that I have been provided with a copy of the Notice of Privacy Practices.

Financial and insurance responsibilities:
_____ I agree to pay for my evaluation and treatments at the time of service, by cash, check, or credit card unless other mutually agreed upon arrangements have been made. I understand it is my responsibility to call my insurance company ahead of time and know my out-of-network benefits. I understand my therapist will provide me with a superbill upon request that is my responsibility to submit to my insurance company.

Current COVID-19 Policy:
____ At By Design, we continue to encourage the use of face masks in our office.
We continue to work hard to keep our clinic a safe space for our patients and staff. If you are showing signs of any illness, COVID-19 symptoms or otherwise, please reschedule.
If you are someone who has health issues and you're concerned about coming into the clinic, telehealth visits may be an option for you. For details please feel free to contact our office.

Direct Access to Physical Therapy
____ In California, you do not need a doctor's referral to see a physical therapist.
Californians have had Direct Access to physical therapy since 2014. In most situations, you can be evaluated and treated by a licensed physical therapist without the previously required physician referral/prescription.

Direct Access in California does have limitations.

- You can receive physical therapy for 45 days or 12 visits, whichever comes first.
- At that point, in order to continue treatment, you would need to obtain a referral to continue care.
- We prefer to have an open line of communication with your health care team in case we find any "red flags" that need other diagnostic testing. We are willing to contact your health care provider after your first visit to make sure everyone is in agreement with our plan of care.

I have read the above information and I consent to physical therapy evaluation and treatment. By initialing above and signing below, I acknowledge that I have read, understand and will abide by the conditions and policies noted on this consent form.

____ ____________________
Print Name Date

_________________________________ ____________________________
Patient's signature (if minor, parent or legal guardian must sign) Therapist Signature / Date

NOTICE OF PRIVACY PRACTICES
Effective Date: April 14, 2023

By Design Physical Therapy, Inc

PLEDGE REGARDING MEDICAL INFORMATION

California State Law under the California Confidentiality of Medical Information Act (California Civil Code §§56 et seq) governs a patient's right to access their healthcare information maintained by a healthcare provider. We are required by law to:

- Make sure that medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the notice that is currently in effect.

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your physicians or others working in this office.

Your Rights Regarding Health Information About You

- ➢ **Right to Inspect and Copy.**
- ➢ **Right to Amend.**
- ➢ **Right to an Accounting of Disclosures.**
- ➢ **Right to Request Restrictions.**
- ➢ **Right to Request Confidential Communications.**

A complete written notice is available and will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. You will be asked to acknowledge and sign a notice regarding HIPAA (the acronym for the Health Insurance Portability and Accountability Act) on your initial visit with Kathy Fry, PT, DPT, OCS.