



Patient Registration Form

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____ Country: _____

Cell Phone: _____ Home Phone: _____

E-mail Address: _____ Work Phone: _____

Would you like to be added to our mailing list? Yes / No (circle one)

Preferred contact method: Home phone / Cell Phone / Work Phone / Email (circle one)

Date of Birth: _____ Sex: Male / Female (circle one)

How did you hear about us? _____ Referred by: _____

Have you visited our website? Yes / No (circle one)

Do you utilize social networking sites? If so, which? _____

Person to Notify in Emergency: _____

Relationship: _____ Phone #: (_____) _____

Payment Authorization and Patient Responsibility

I hereby authorize the Pelvic Health and Rehabilitation Center to furnish my insurance company with any information that may be requested concerning payments of benefits. I understand that I am financially responsible for all charges, whether covered by my insurance or not. I further understand that it is my responsibility to obtain the necessary referrals and/or pre-authorizations from my insurance company.

Signature: _____ Date: _____

If patient is a minor, authorization to treat patient.

Signature: _____ Date: _____

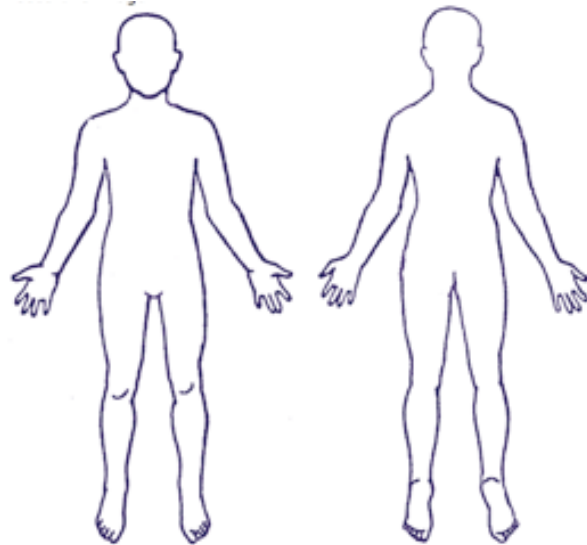
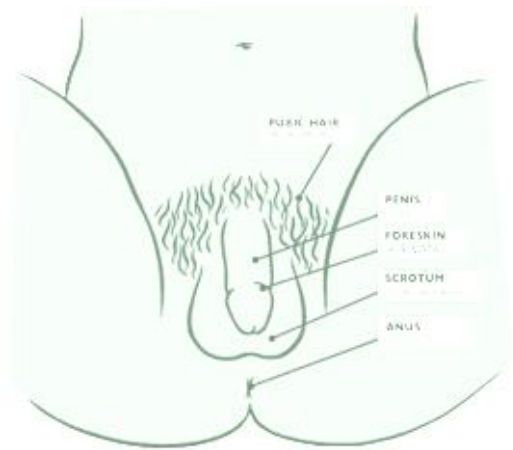


New Patient Questionnaire (Male)

1. What brought you to the Pelvic Health and Rehabilitation Center?

2. What are your goals for treatment?

Please mark the location of your symptoms below.



3. Please describe how your symptoms are limiting your professional and/or personal life.

4. Please describe any concerns you have regarding your urinary function.

5. Please describe any concerns you have regarding your bowel function.

6. Please describe any concerns you have regarding your sexual function.

7. Please list your current medications including dosage.

8. Please list all medical and alternative health providers you have seen regarding this problem.

9. Please list all surgeries.

10. Please list all treatments, including effectiveness, you have undergone for this problem.

11. Please list all diagnostic procedures you have undergone for this problem.

12. Additional comments:

Male Patient Questionnaire

Name: _____ Date: _____

Referral Source: _____ Date of Birth: _____

1. In the last week, have you experienced any pain or discomfort in the following areas?

- | | | |
|--|---------|--------|
| a. Area between rectum and testicles (perineum) | 2 - yes | 1 - no |
| b. Testicles | 2 - yes | 1 - no |
| c. Tip of the penis (not related to urination) | 2 - yes | 1 - no |
| d. Below your waist, in your bladder or pubic area | 2 - yes | 1 - no |

2. In the last week, have you experienced:

- | | | |
|---|---------|--------|
| a. Pain or burning during urination | 2 - yes | 1 - no |
| b. Pain or discomfort during or after sexual climax (ejaculation) | 2 - yes | 1 - no |

3. How often have you had pain or discomfort in any of these areas over the last week?

- a. Never 1
- b. Rarely 2
- c. Sometimes 3
- d. Often 4
- e. Usually 5
- f. Always 6

4. Which number best describes your AVERAGE pain or discomfort on the days that you had it, over the last week?

1 2 3 4 5 6 7 8 9 10
No Pain Pain As
Bad as
You Can
Imagine

Urination

5. How often have you had a sensation of not emptying your bladder completely after you finish urinating, over the last week?

- a. Not at all 0
- b. Less than 1 times in 5. 1
- c. Less than half the time. 2
- d. About half the time. 3
- e. More than half the time. 4
- f. Almost always. 5

6. How often have you had to urinate again less than two hours after you finished urinating, over the last week?

- a. Not at all 0
- b. Less than 1 times in 5. 1
- c. Less than half the time. 2
- d. About half the time. 3
- e. More than half the time. 4
- f. Almost always. 5

Impact of Symptoms

7. How much have your symptoms kept you from doing things you would usually do, over the last week?

- a. None 0
- b. Only a little 1
- c. Some 2
- d. A lot 3

8. How much did you think about your symptoms, over the last week?

- a. None 0
- b. Only a little 1
- c. Some 2
- d. A lot 3

Quality of Life

9. If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that?

- a. Delighted 0
- b. Pleased 1
- c. Mostly satisfied 2
- d. Mixed (about equally satisfied and unsatisfied) 3
- e. Unhappy 4
- f. Terrible 5

Scoring Patient Symptom (For Office Use Only)

Pain: Total of items 1a, 1b, 1c, 1d, 2a, 2b, 3 and 4 = _____

Urinary Symptoms: Total of items 5 and 6 = _____

Quality of Life Impact: Total of items 7, 8 and 9 = _____

The National Institute of Health Chronic Prostatitis Symptom Index (NIH-CPSI) captures the three most important domains of the pelvic patient experience: pain (location, frequency, and severity), voiding (irritative and obstructive symptoms), and quality of life (including impact). This index is useful in research studies and clinical practice. (From Litwin MS, McNaughton-Collins M, Fowler FJ, et al: The NIH Chronic Prostatitis Index [NIH-CPSI]: Development and validation of a new outcome measure. J Urol 1999; 162:369-375.)

PHRC Patient Policies
Effective January 1, 2011

**Please
Initial**

New and Current Patients: Welcome to the Pelvic Health and Rehabilitation Center! We look forward to working with you. Please read the following information and feel free to ask any questions you may have.

Office Hours: Monday-Friday 8:00am-6:00pm by appointment only.

x Insurance: We do not contract or participate with insurance plans other than Brown and Toland Medical Group. Patients without Brown and Toland are responsible for payment of the entire cost of the visit upon conclusion of the appointment. Brown and Toland patients are responsible for ensuring they are authorized for treatment at the time services are rendered, and for any co-payments they may have.

x MediCare: We are not a contracted Medicare provider. As an unfortunate result, federal law prohibits us from treating MediCare Part B recipients, regardless of payment method. Therefore, by signing this document, you are confirming that you are not a current MediCare Part B recipient.

Insurance Billing: Patients will be provided with a copy of their bill at the end of each visit and they can submit the bill to their insurance company if they so choose. We will also assist patients in facilitating reimbursement if necessary.

Medical Record Copies: We charge for copies of medical records when requested from patients, insurance companies, and other doctor's offices. The patient is responsible for all copy charges. Copy charges are \$25.00 for small records and \$50.00 for large records.

Appointments: Appointments can be made either during phone hours or with your provider. At any given time, our books will be open for the current month and the following month. For example, as of August 1st our books will be open for August and September. As of September 1st, our books will be open for September and October. Patients are responsible for knowing their scheduled appointments as reminder calls will not be made.

x Appointment Cancellations: The Pelvic Health and Rehabilitation Center has an extensive waiting list for appointments. As a result, we ask that patients provide at least **24 hours** notice if you cannot keep your appointment. If an appointment cannot be kept, or less than 24 hours notice is given, the patient is responsible for the entire cost of the visit.

A credit card is required to hold new patient appointments. In the event of a missed appointment or insufficient time frame for cancellation, the credit card will be charged the cost of the visit. This signed consent form is required from all patients.

If a patient misses 3 appointments, the Pelvic Health and Rehabilitation Center reserves the right to cancel all future appointments.

Late Arrivals: Patient will be charged the fee for the entire scheduled appointment regardless of the time the patient arrives.

Privacy Notice: A copy of our Notice of Privacy Practice is available upon request.

Print Name: _____

Signature: _____

Date: _____

Pelvic Health and Rehabilitation Center

Consent for Evaluation and Treatment

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, dysfunction or pain with bowel, bladder or sexual function, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, 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/or palpating the perineal region, including the vagina and or rectum externally and/or internally. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar and nerve mobility and tenderness, as well as the function of the pelvic floor region.

Treatment may include, but not be limited to the following: observation, palpation, stretching and strengthening exercises, relaxation techniques, soft tissue and/or joint mobilization and educational instruction. Evaluation and treatment may result in emotional distress or discomfort, and that if I am unable to tolerate the evaluation or treatment I have the right to terminate the therapy session at any time.

I understand that in order for 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 program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

1. The purpose, risks, and benefits of this evaluation have been explained to me.
2. I understand that I can terminate the procedure at any time.
3. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the procedure.
4. I have the option of having a second person present in the room during the procedure. If I elect to have a second person present in the room I understand I am responsible for providing a volunteer to be present during the examination and/or treatment.

Please circle one:

I will provide a 2nd person in the room

I decline this option

Patient Name (Please Print)

Patient Signature

Witness Name (Please Print)

Witness Signature

DATE: _____

Pelvic Health and Rehabilitation Center Cancellation Policy

The scheduling of an appointment involves the reservation of time specifically for you. In the event of a “no show” or failure to give a **24-hour notice** of a cancellation, **you will be charged the full session fee for all late cancellations and missed appointments.** Please be aware that insurance companies will not cover cancellation charges.

If you are unable to keep your appointment, please notify us as soon as possible. 48 hours advance notice is preferred and 24 hours advanced notice is required to avoid charges. We understand that extenuating circumstances may prevent you from providing 24 hours advanced notice, and we will evaluate these situations on a case by case basis.

Credit Card Authorization:

I, _____, authorize the Pelvic Health and Rehabilitation Center to charge the full session fee to the credit card indicated below in the event that I fail to give at least 24 hours notice of cancellation of a scheduled appointment.

Card Type (circle one): Visa Mastercard American Express

Card Number: _____ Exp. Date _____

CV2 code (3-digit code on back of card or 4 digit code on front of Amex) _____

Name as printed on card _____ Billing zip code _____

I have read the above fee agreement carefully and agree to its terms and conditions.

Authorized cardholder signature _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practice

Of the Pelvic Health and Rehabilitation Center

2000 Van Ness Avenue, Suite 603, San Francisco, CA 94109

I understand that, under the *Health Insurance Portability & Accountability Act of 1996* (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can 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 acknowledge that I have been informed of the Pelvic Health and Rehabilitation Center’s *Notice of Privacy Practices* which contains a more complete description of the uses and disclosures of my health information.

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. 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 at the above address to obtain a current copy of the Notices of Privacy Practices. I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

Patient Name (print): _____

Signature: _____

Date: _____