

Women's Health New Patient Information Form

Name: _____ Date of Birth: _____

Home Address Street: _____ Apt. _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Best Email : _____ @ _____

Emergency Contact: _____ Phone: _____

Release of Information:

I hereby authorize Wellbridge Physical Therapy to discuss my personal healthcare information regarding my treatment including diagnosis/prognosis, billing and payment for services rendered on my behalf, and scheduling to the person(s) listed below:

Name (print)	Relationship	Phone number

Name (print)	Relationship	Phone number

Physician Information

Referring Physician: _____ Location: _____

Phone: _____ Fax: _____

PCP: _____ Location: _____

Phone: _____ Fax: _____

Insurance/ Injury Information Is this injury employment related? YES / NO

Is this injury due to a Car Accident? YES / NO. DOA: _____

Have you received homecare in the last 6 months? YES/NO

How did you hear about us? _____

HOW WOULD YOU LIKE TO RECEIVE YOUR APPOINTMENT REMINDERS? Email/ Text

*****Please present your insurance card for photocopying*****

Health History Form

Your Name: _____ Date of Birth: _____

Describe the current problem that brought you here: _____

When did your problem first begin? _____ Months ago or _____ Years ago

Was your first episode of the problem related to a specific incident? Yes/No

Please Describe: _____

Describe previous treatment/exercises?

Activities/events that cause or aggravate your symptoms (please check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Sitting greater than _____ minutes | <input type="checkbox"/> Walking greater than _____ minutes |
| <input type="checkbox"/> Standing greater than _____ minutes | <input type="checkbox"/> Changing positions (i.e. sit to stand) |
| <input type="checkbox"/> Light activity (light housework) | <input type="checkbox"/> Vigorous activity/exercise (run/jump) |
| <input type="checkbox"/> Sexual activity | <input type="checkbox"/> With cough/sneeze/straining |
| <input type="checkbox"/> With laughing/yelling | <input type="checkbox"/> With lifting/bending |
| <input type="checkbox"/> With cold weather | <input type="checkbox"/> With triggers (running water/key in door) |
| <input type="checkbox"/> With nervousness/anxiety | <input type="checkbox"/> No activity affects the problem |
| <input type="checkbox"/> Other? Please list: _____
_____ | |

Are you currently pregnant? YES/NO

Ob/Gyn History:

Y/N Vaginal deliveries # _____

Y/N Vaginal dryness

Y/N Episiotomy # _____

Y/N Painful periods

Y/N C-Section # _____

Y/N Menopause – when? _____

Y/N Difficult childbirth # _____

Y/N Painful vaginal penetration

Y/N Prolapse or organ falling out

Y/N Pelvic pain

What relieves your symptoms? _____

How has your lifestyle/quality of life been affected because of this problem?

Social activities (exclude physical activities) _____

Diet/fluid intake _____

Physical activity _____

Work _____

Other _____

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

What are your treatment goals/concerns? _____

Medical History: Please check if you have, or have ever had, any of the following:

- | | |
|--|--|
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Osteoporosis/low bone density |
| <input type="checkbox"/> Heart related issues | <input type="checkbox"/> History of fractures/broken bones |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Vision or hearing problems |
| <input type="checkbox"/> Lung disease/breathing issues | <input type="checkbox"/> MRSA/Staph infection |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> History of cancer (type: _____) | <input type="checkbox"/> Unusual dizziness |
| <input type="checkbox"/> Unexplained recent weight loss | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Increased pain at night | <input type="checkbox"/> Changes in bowel/bladder function |
| <input type="checkbox"/> Recent increase in headaches | <input type="checkbox"/> Recent falls |
| <input type="checkbox"/> Changes in sensation (numbness/tingling) | <input type="checkbox"/> Drug or alcohol abuse issues |
| <input type="checkbox"/> Circulation or vascular problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Neurological problems (ex: seizure/stroke/MS) | <input type="checkbox"/> Other: _____ |

Please List ALL Current Medications: _____

Please List ALL Surgeries and Approximate Dates: _____

Patient's Signature: _____ Date: _____

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Problems

- | | | | |
|-----|---------------------------------------|-----|---------------------------------------|
| Y/N | Trouble initiating urine stream | Y/N | Blood in urine |
| Y/N | Intermittent/slow urine stream | Y/N | Painful urination |
| Y/N | Difficulty stopping the urine stream | Y/N | Trouble feeling bladder urge/fullness |
| Y/N | Trouble emptying bladder completely | Y/N | Current laxative use |
| Y/N | Straining or pushing to empty bladder | Y/N | Trouble feeling bowel urge/fullness |
| Y/N | Dribbling after urination | Y/N | Constipation/ straining |
| Y/N | Constant urine leakage | Y/N | Trouble holding back gas/feces |
| Y/N | Other - describe: _____ | Y/N | Recurrent bladder infection |

1. Frequency of urination: times per day _____ 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 _____

5. 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? _____

6. If constipation is present, describe management techniques:

7. 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

8. Do you have a feeling of an organ "falling out" / prolapse or pelvic heaviness/pressure?

___ None present

___ How many times per month (specify if related to activity or your period)?

___ With standing for _____ minutes or _____ hours

___ With exertion or straining ___ Other _____

Skip questions if no leakage/incontinence

9a. Bladder leakage – number of episodes

- No leakage
- Times per day
- Times per week
- Times per month
- Only with exertion/strong urge

10a. On average, how much urine do you leak?

- No leakage
- Just a few drops
- Wets underwear
- Wets outerwear
- Wets the floor

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

- None
- Minimal protection (tissue paper/paper towel/panty shields)
- 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 _____

9b. Bowel leakage - number of episodes

- No leakage
- Times per day
- Times per week
- Times per month
- Only with exertion/strong urge

10b. How much stool do you lose?

- No leakage
- Stool staining
- Small amount in underwear
- Complete emptying

PELVIC FLOOR 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; difficulty with bowel, bladder, or sexual functions; 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.

This evaluation will assess skin conditions, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

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 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 evaluation.

4.I have the option of having a second person present in the room during the procedure and _____ choose _____ refuse this option.

Patient Name: _____

Date: _____

Patient Name: _____

Notice of Privacy Practices

_____ Initial I hereby acknowledge that I have been made aware of Wellbridge Physical Therapy's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is available at the front desk, and that I may request a copy of any amended Notice of Privacy Practices at any time. I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have acted relying on this consent.

Authorization to Release / Obtain Information

_____ Initial I hereby authorize the release of my patient health care information for the purposes of treatment or payment, to my physician, insurance company, adjustor, attorney, or other health care organizations pertinent to my case. Further, I authorize Wellbridge Physical Therapy to obtain needed information from my physician, insurance company, adjustor, attorney and any other health care organization pertinent to my case. This correspondence can be made via mailings, telephone and/or facsimile.

Appointments / Cancellations

_____ Initial We advise you to schedule your appointments in advance. Maintaining a consistent schedule ensures your best outcome for a speedy recovery. Being late by more than 15 minutes will require you to either reschedule your appointment or wait for the next available opening. We expect you to keep all of your appointments with Wellbridge Physical Therapy and require 24 hours notice if you are unable to keep an appointment, anything less will result in a \$25 charge to your credit card on file. Failure to show up for an appointment with no notice will result in a \$50 charge to your credit card on file. These charges are not reimbursed by any insurance company.

Financial Responsibility

_____ Initial Co-pays are due at the time of treatment. I agree to pay Wellbridge Physical Therapy all amounts that are due for services rendered which are not otherwise paid for by my insurance plan on my behalf. 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 for services rendered including, without limitation, reasonable attorney's fees.

If you are experiencing financial hardship and are unable to afford the cost of our services, we may be able to work out a payment plan with you. Please speak with the office manager for details.

Assignment & Release of Benefits

_____ Initial I hereby appoint Wellbridge Physical Therapy as my authorized representative, and assign to it my right, to file for, receive and recover any and all monies payable for the care which it rendered to me from any third party claims payment source, including my health insurer, Medicare, Medicaid or other governmental program (collectively, my "Plan"), while I was eligible to receive such claim payment. I authorize you to send and receive documentation related to my treatment to, and consent to your discussing my treatment with, my Plan." I also authorize Wellbridge Physical Therapy to take any and all actions necessary to assert and pursue my legal rights to receive such claim payment under the terms of my Plan through any appeals and/or grievances and/or litigation and/or arbitration available to me for such purpose. As the assignor of the foregoing payment amounts, I direct that such payment be sent by my Plan to Wellbridge Physical Therapy and, in the case that payment is made by my Plan to me, I agree to remit such payment in full to Wellbridge Physical Therapy no later than ten (10) days after my receipt.

Insurance Eligibility

_____ Initial Verification of benefits is NOT a guarantee of payment. Payment is determined by your insurance company at the time a claim is received. We provide you with the information as it is outlined by your insurance company. It is your responsibility to fully understand your insurance benefits.

Primary Insurance: _____ HMO/PPO

Deductible _____ Remaining _____

Out-of-Pocket _____ Remaining _____

Copay _____ Coinsurance _____ Prior Authorization Required _____

Secondary Insurance: _____ HMO/PPO

Patient Signature (Parent/Guardian if patient under 18 years) _____

Printed Name _____

Date _____

PATIENT INFORMATION RE: CREDIT CARD ON FILE POLICY

As you are aware, healthcare has undergone dramatic changes in the past few years. High-deductible health plans are now a mainstay in the healthcare landscape. This means that more responsibility of the payment is being placed on patients. We need to be sure that patient balances are paid in a timely manner. If you have ever stayed in a hotel or rented a car you are familiar with the concept of having a credit card on file. Your credit card information is stored in a secure, encrypted manner and only accessed and charged if there is an outstanding balance. As of January 1, 2025, Wellbridge Physical Therapy has adopted a Credit Card on File Policy.

At the time of registration, we will request your credit card information. Your credit card numbers will be encrypted and stored securely. Once we receive your Explanation of Benefits (EOB) (what the insurance company will pay towards your visit), we will wait 30 days to allow you time to pay the balance on your account. If your balance is not paid your credit card will be charged for the outstanding balance that is your responsibility. Co-pays must be paid at the time of visit. If you have any questions about this payment method, please do not hesitate to contact us at 603-488-5808.

How does credit card on file benefit me?

Using credit card on file, you will be able to:

- Pay balances and co-pays conveniently
- Make payments automatically using your credit card of choice
- Avoid writing checks to pay bills by mail
- Receive notifications and receipts via email
- Keep bills paid to avoid collecting a large balance

Your credit card on file can be used for the following reasons:

- Co-pays
- Co-pays not collected from you at the beginning of the visit
- No show or late cancellation fees
- Outstanding balances greater than 31 days past due

Credit Card Number	Exp Date	Name as it appears on card		
Billing Address		City	State	Zip
Patient Name	Patient DOB	Patient Name	Patient DOB	

I authorize Wellbridge Physical Therapy to charge the above credit card above per the terms of this policy. This authorization shall remain in effect until WBPT has received written notification from me of its termination.

Signature	Date
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Unfortunately, we are unable to book future appointments if this form is not accurately filled out and signed.