Pediatric Registration Packet
Pelvic Floor Physical Therapy

Scan No. _____

Initials _____

PATIENT INFORMATION

Patient Name (Last, First, Middle Initial)		Marital Status: M S W D Circle One: Female or Male	
Address		Social Security Number	Date of Birth
City	State Zip Code	Email Address	
Best Contact Number	Emergency Contact Name/Number		

What type of appointment reminder do you prefer? □ Email □ Phone call

What format do you prefer for your rehab documents and home exercise program? □ Email □ Printed handouts

Are you receiving any nursing, aide, or therapy services in your home? □ Yes □ No *(If yes, notify the Front Office)*

For Medicare beneficiaries, have you received therapy in this calendar year? □ Yes □ No

Is this a Workers' Comp injury? □ Yes □ No Date of Injury: _____ Adjustor: _____ Employer: _____

INSURANCE INFORMATION

Primary:	Secondary:	Tertiary:
Policy/ID#:	Policy/ID#:	Policy/ID#:
Name of Policy Holder:	Name of Policy Holder:	Name of Policy Holder:
Relationship to Patient:	Relationship to Patient:	Relationship to Patient:
Date of Birth (Policy Holder):	Date of Birth (Policy Holder):	Date of Birth (Policy Holder):
SS# of Insured (Policy Holder):	SS# of Insured (Policy Holder):	SS# of Insured (Policy Holder):
Effective Date:	Effective Date:	Effective Date:
Group Number:	Group Number:	Group Number:

Below is an estimation of benefits. It may be subject to change based on your insurance.

YTD Deductible $:	YTD Deductible $:	YTD Deductible $:
YTD Deductible Met $:	YTD Deductible Met $:	YTD Deductible Met $:
Co-Pay Per Visit $:	Co-Pay Per Visit $:	Co-Pay Per Visit $:
Estimated Co-Insurance Per Visit $:	Estimated Co-Insurance Per Visit $:	Estimated Co-Insurance Per Visit $:
Insurance Coverage %:	Insurance Coverage %:	Insurance Coverage %:
Patient's %:	Patient's %:	Patient's %:
Total Visits Authorized: Visits Available: Auth End Date _____ $ Limit_____ Are we in network? □ Yes □ No	Total Visits Authorized: Visits Available: Auth End Date _____ $ Limit_____ Are we in network? □ Yes □ No	Total Visits Authorized: Visits Available: Auth End Date _____ $ Limit_____ Are we in network? □ Yes □ No

Dear Parent/Guardian,

For insurance to cover your child's treatment here, the following information is required.

Is your child receiving special services or therapy treatment from the local independent school district? □ Yes □ No

If YES, please provide a copy of your child's current IEP/ARD if receiving any services from your school district.
If NO, please complete the following statement:

To Whom It May Concern:

I am the parent/guardian of _____.
(Please Print Child's Name)

My Child is NOT receiving special services or therapy treatment from the local independent school district.

_____ _____ _____
Parent/Guardian Signature Parent/Guardian Printed Name Date

For our emergency records, please complete the following:

MEDICAL RELEASE

I, _____, Parent or Legal Guardian of _____
In my absence hereby authorize any Medical or Surgical treatment which may be necessary in an emergency situation while attending Integrity Rehab, for the wellbeing of the above mentioned minor. I agree to hold Integrity Rehab, the physician, and/or the hospital treating the above mentioned minor, harmless.

EMERGENCY MEDICAL INFORMATION

Drugs/Allergies/Special Medication Needs_____

Chronic Diseases/Other Health Problems_____

Pediatric Medical/Pelvic Floor History (1)

Patient Name: _____
Date of Birth: _____

Name of your Primary Care Physician: _____ Location: _____

Describe reason/s seeking therapy services:

Please explain the problem more and tell when you first noticed the problem. Did it occur suddenly or gradually?

What do you think may have caused the problem?

Has the problem changed in the past year? ____Yes ____No Explain: _____

Please list specialist/s seen (Neurologist, Psychologist/Psychiatrist, Urologist, etc.)

DATE LOCATION SPECIALIST RESULTS

Check person/s child lives with: ___Father ___Mother ___Step-father ___Step-mother ___Other: _____

Please list diagnostic tests (i.e. urinalysis) performed for current problem:

DATE LOCATION DIAGNOSTIC TESTS RESULTS

Check the following conditions your child has been diagnosed with or is having current symptoms.

___Abuse (physical or sexual)
___ADD/ADHD
___Allergies
___Anemia
___Asthma
___Autism Spectrum Disorder (ASD)
___Birth Injury
___Bladder Infections
___Blood in Urine
___Breathing Problem/s
___Cerebral Palsy
___Depression
___Diabetes
___Down's Syndrome
___Ear Problem/s
___Epilepsy
___Fevers – High/Prolonged
___Hearing Loss
___Heart Problem/s
___Intellectual Disability-ID
___Latex Sensitivity/Allergy
___Low Back Pain
___Kidney Infections
___Kidney Disease
___Multiple Sclerosis
___Neurological (brain, nerve) Problem/s
___Pelvic Pain
___Premature Birth
___Rheumatoid Arthritis
___Seizures
___Spina Bifida
___Stroke
___Vesicoureteral Reflux Grade
___Other: _____

Please list any hospitalizations, injuries, and other chronic or severe illness your child has experienced:

DATE HOSPITALIZATIONS/INJURIES/OTHER REASON

Please list all PRESCRIPTION (Rx) and OVER THE COUNTER (OTC) medications your child is currently taking (Include all injectable, oral, rectal, and topical medications):

Pediatric Medical/Pelvic Floor History (2)

Patient Name: _____

Date of Birth: _____

Bladder History:

Urinary frequency: _____Times per day _____Times per night

Ability to hold urine

(after the urge to urinate) ____Not at all ____1-2 min ____3-10 min ____11-30 min ____31-60 min

Wets bed: ____Yes ____No If yes, how often per week?____

Difficulty passing urine: ____Yes ____No If yes, how often? ___All the time ___Occasionally

Explain:_____

Amount of urine passed: ____Very small _____Small _____Average ____Large

Urinary leakage: ____Yes _____No If yes, is it constant?__ Times per day:___ Per week:___

Amount of leakage: ____None _____Few drops _____Wets underwear ____Wets outer clothes

Activity when leakage noted: ____With cough/sneeze _____With exercise ____With strong urge to urinate

Triggers/encourage urination: ____Yes _____No ____Running water ____ Hands in water

____Other: _____

How problem affects child: ____Not at all ____ Small concern ___ Moderate concern ____Major concern

Bowel History:

Frequency of bowel movements: _____Per day _____Per week

Bowel consistency: _____Loose _____Normal ____Hard

History of constipation: _____Yes _____No If yes, when noticed? _____

Strain to have a bowel movement: _____Yes _____No If yes, how many times per week? _____

Ignore the urge to defecate: _____Yes _____No If yes, how often? _____

Bowel leakage: _____Yes _____No If yes, how often per day?_____ per week?____

Amount of leakage: _____None _____Staining _____Small amount ____Complete emptying

Activity when leakage noted: _____Playing _____Exercise _____Cough/Sneeze ____Strong urge to go

_____Other: _____

Protection worn: _____None _____Tissue paper/ paper towel ___Diaper ___Pull-ups

Fluid Intake: Problem: ____YES ____ NO

Water drinking: ____None ____1-3 glasses per day ____4-6 glasses per day ____7 or more glasses per day

Fruit juice: ____None ____1-3 glasses per day ____4-6 glasses per day ____7 or more glasses per day

Caffeinated beverages: ____None ____1-3 glasses per day ____4-6 glasses per day ____7 or more glasses per day

Non-caffeinated soda: ____None ____1-3 glasses per day ____4-6 glasses per day ____7 or more glasses per day

Other_____: ____None ____1-3 glasses per day ____4-6 glasses per day ____7 or more glasses per day

What amount of the above fluid intake occurs between 8 am and 6 pm? ___All ___1/2 ___3/4 ___None

What fluid and how much is taken at bedtime? _____

Please list past trials and effectiveness:

_____

_____

_____

_____

Integrity REHAB

Pediatric Medical/Pelvic Floor History (3)

Patient Name: _____

Date of Birth: _____

Some find that bladder, bowel, or pelvic symptoms affect their activities, relationships, and feelings. For each question, place an X in the response that best describes how much your activities, relationships, or feelings have been affected by your bladder, bowel, or pelvic symptoms or conditions over the last three (3) months. Please be sure to mark an answer in all three (3) columns for each question. Thank you for your cooperation.

How do symptoms or conditions related to → usually affect your:	Bladder or urine	Bowel or rectum	Pelvis
1. Ability to do household chores (cooking, housecleaning, laundry)?	__ Not at all __ Somewhat __ Moderately __ Quite a bit	__ Not at all __ Somewhat __ Moderately __ Quite a bit	__ Not at all __ Somewhat __ Moderately __ Quite a bit
2. Ability to do physical activities such as walking, swimming, or other exercise?	__ Not at all __ Somewhat __ Moderately __ Quite a bit	__ Not at all __ Somewhat __ Moderately __ Quite a bit	__ Not at all __ Somewhat __ Moderately __ Quite a bit
3. Entertainment activities such as going to a movie or concert?	__ Not at all __ Somewhat __ Moderately __ Quite a bit	__ Not at all __ Somewhat __ Moderately __ Quite a bit	__ Not at all __ Somewhat __ Moderately __ Quite a bit
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	__ Not at all __ Somewhat __ Moderately __ Quite a bit	__ Not at all __ Somewhat __ Moderately __ Quite a bit	__ Not at all __ Somewhat __ Moderately __ Quite a bit
5. Participating in social activities outside your home?	__ Not at all __ Somewhat __ Moderately __ Quite a bit	__ Not at all __ Somewhat __ Moderately __ Quite a bit	__ Not at all __ Somewhat __ Moderately __ Quite a bit
6. Emotional health (nervousness, depression, etc.)?	__ Not at all __ Somewhat __ Moderately __ Quite a bit	__ Not at all __ Somewhat __ Moderately __ Quite a bit	__ Not at all __ Somewhat __ Moderately __ Quite a bit
7. Feeling frustrated?	__ Not at all __ Somewhat __ Moderately __ Quite a bit	__ Not at all __ Somewhat __ Moderately __ Quite a bit	__ Not at all __ Somewhat __ Moderately __ Quite a bit

ADDITIONAL INFORMED CONSENT FOR ASSESSMENT, TREATMENT, AND EVALUATION OF PELVIC FLOOR DYSFUNCTION

Pelvic Floor Dysfunctions: Adult pelvic floor dysfunctions include pelvic pain syndromes, urinary incontinence, fecal incontinence, dyspareunia or pain with intercourse, erectile dysfunction, pain from an episiotomy or scarring, vulvodynia, vestibulitis, or other similar complications. Pediatric pelvic floor dysfunctions include bladder and bowel problems.

Prior to Treatment: Therapist will inform patient or caregiver of the benefits of the vaginal/rectal assessment, treatment, evaluation, and options available for a particular pelvic dysfunction. If patient/caregiver is uncomfortable with the assessment or treatment AT ANY TIME, please inform therapist, the procedure will be discontinued and alternatives will be discussed. If patient is pregnant, has an infection of any kind, has vaginal dryness, less than six (6) weeks postpartum or post surgery, has severe pelvic pain, sensitivity to KY jelly, vaginal creams, or latex, please inform the therapist prior to the pelvic floor assessment.

Assessment: Initially and periodically the therapist may perform a muscle assessment of the pelvic floor to assess muscle strength, length, range of motion, and scar mobility. Palpitation of these muscles is most direct and accessible if done via the vagina and/or rectum.

Treatment and Evaluation: The therapist will explain all treatment procedures with the patient/caregiver who may choose to participate or not participate with all or part of the treatment plan. Treatment procedures include, observation, education, and stretching and strengthening exercise In addition, treatment may include several manual techniques including palpation, massage, joint and soft tissue mobilization, ultrasound, use of vaginal weights, vaginal or rectal sensors for biofeedback, and/or electrical stimulation.

Potential Risks: There may be an increase in current level of pain or discomfort, or an aggravation of an existing injury. The discomfort is usually temporary and will probably subside in 24 hours.

Potential Benefit: There may be an improvement in symptoms and an increase in ability to perform daily activities. There may be increased strength, awareness, flexibility and endurance in movements. Decreased pain and discomfort may be experienced. In addition, a greater knowledge about managing symptoms/condition and resources will be available.

Alternatives: Available physical therapy treatment options will be explained and will be made available. Further medical, surgical, or pharmacological alternatives may be discussed with your physician or primary care provider.

Cooperation with Treatment: In order for therapy to be effective, please keep scheduled appointments and follow through with the assigned home physical therapy program.

Informed Consent: Means that the potential risks, benefits, and alternatives of therapy evaluation have been explained. Integrity Rehab therapists do not promise a cure for, or improvement, in your condition.

I have read and understand the above information. Based on the information received from the therapist, I consent to physical therapy treatment and may withdraw at any time.

Patient signature and date

Authorized agent signature and date

Relationship to patient

CONSENT FOR TREATMENT: I hereby authorize Integrity Rehab to provide therapy services to _____ that have been ordered by my (his/her) physician and are under the direct supervision of a licensed health care professional. I also understand that it is my (his/her) right to accept or refuse medical treatments.

AUTHORIZATION OF RELEASE OF INFORMATION AND PAYMENT: In applying for payment under Title XVIII or Title XIX of the Social Security Act, or other third party payer sources, I certify that the information given by me or a person authorized by me is correct. This authorization and request shall begin on _____ (TODAY'S DATE), and continue until such time that it is revoked by me, my legal representative, physician or this clinic. I also agree if there are any changes to the billing information (i.e., change in insurance company or policy, becoming ineligible or eligible for Medicare and/or Medicaid, etc.) that I will notify the clinic immediately. If I fail to report changes with my insurance to Integrity Rehab's billing department I will be financially liable/responsible. I understand that I am financially responsible for all charges that my insurance company does not pay. I authorize the release of any information necessary in order to process any billing.

RELEASE OF INFORMATION/CONFIDENTIALITY: I hereby authorize any physician, hospital/medical facility, laboratory, or other health care provider to release to Integrity Rehab any information requested by them for the purpose of continuity of care. I also authorize Integrity Rehab to release any of my (his/her) health care information from them to other health care providers involved in my (his/her) care, or any facility where I (he/she) may be admitted for the purpose of continuity of care. A written consent from patient or legal representative is required to release medical information to persons not otherwise authorized by law (federal and state). For pediatric patients I agree to the Pediatric Speech Therapy Procedures.

NOTICE OF NON-DISCRIMINATION: Integrity Rehab does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, or national origin, or on the basis of disability or age.

GRIEVANCE/COMPLAINT PROCEDURE: Should I have a grievance or complaint; I understand that every attempt will be made to rectify the situation without fear of reprisal. I may contact the Clinic Director, Compliance Officer, or Administrator by calling (254) 699-3933 or emailing Compliance@IntegrityRehab.net. If the grievance or complaint is not resolved to my satisfaction, I may follow the printed "Consumer Information Notices" in the Reception area.

PHOTOGRAPHY: I DO ___ DO NOT ___ authorize Integrity Rehab to photograph, videotape, or audio record me (him/her) for medical education or reasons related to treatment and/or promotion of Integrity Rehab operations. Patient's name will not be used.

INFORMATION RECEIVED: I have reviewed a laminated copy of the following information to read and understand: 1) Notice of Privacy Practices, 2) Cancellation and No-Show Policy, and 3) General Health Guidelines. I may request a copy to take home with me. For pediatric patients, in addition to the preceding information, I have reviewed a laminated copy of Pediatric Speech Therapy Procedures.

In addition, the following NEW PATIENT INFORMATION is available upon request:

- Abuse, Neglect, and Exploitation
- Advance Directives
- Cell Phone Policy
- Children Policy
- Civil Rights
- Disaster/Emergency
- Employee Drug Testing
- Rights of the Elderly

I acknowledge that the information above has been provided to me or is accessible to me in my primary language, or via an interpreter. I certify that the information I have provided in this registration packet is accurate and complete.

Patient signature and date

Authorized agent signature and date

Relationship to patient