Rosipal Institute

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PATIENT REGISTRATION FORM

Today's Date:		
Patient: Last Name	First Name	
Home Phone Number:	Cell Number:	Email:
Street Address		
City	State	Zip Code
DOB	Age	
Marital status (circle one) Single Married Divorced Sep Widowed	Occupation:	
Employer Name:	Address:	
Referring Physician:	Phone Number:	
Primary Care Physician:	Phone Number:	
Emergency Contact Name:	Relationship:	
Emergency Contact Numbers: Home	Work	Cell

INSURANCE INFORMATION

Name of Responsible Party: Last name	First Name	
Date of Birth:	Social Security #	
Address:		
Home Phone:	Cell Phone:	Work Phone:
Insurance Company Name:		
Group #:	Policy #	Member ID#
Name on Policy:	Relationship to Patient:	

Primary Insured Information (if different than patient):

Address:		DOB:
Home Phone	Cell Phone	Work Phone

Rosipal Institute for Pelvic Therapy Solutions
5136 Village Creek Dr. Ste. 502 Plano, TX 75093 Office (972) 735-0920 Fax (972) 735-0919

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GENERAL MEDICAL HISTORY

Date: _____

Name: _____
Last First

Birth Date: _____ Gender: ☐ Male ☐ Female

Birth Place: _____

Allergies: _____
_____
_____

Current medications: _____
_____
_____

Drug Supplements (Any vitamins or over the counter drugs taken on a regular basis): _____
_____

Current/Chronic Medical Conditions:
_____
_____

Surgeries:
_____
_____

What brings you to our office today?
_____
_____

Do you have any special beliefs that would be important for us to know in regards to your medical care? _____
_____

Tobacco Use: ☐ None ☐ Current User

☐ Prior Use: Year Started _____Year Quit _____ Amount _____

Alcohol Use: ☐ None ☐ Occasional use ☐ Weekly ☐ Daily Total # per week: _____

Drug Use: ☐ None ☐ Yes If yes, Type: _____ How often: _____

Do you have Children? If so please provide age/s:_____

Are you currently employed? ☐ Yes ☐ No

Last Pap Smear: _____

Last Mammogram: _____

Last Physical Exam: _____

Birth Control Method, if any:_____

FAMILY HISTORY	Age	Health Issues	If deceased, cause and age
Father			
Mother			
Brothers/Sisters			
Children			

☐ No knowledge of family medical history

Please indicate medical conditions that run in your family. Please indicate also who is/was affected by these conditions:

Asthma :	Headaches:
Seizures	Liver Disease:
Cholesterol:	Hypothyroid (Low):
Allergies:	Hyperthyroid (High):
Mental Illness:	Heart Attacks:
Alcoholism:	High Blood Pressure:
Lung Dis.:	Stroke:
Diabetes	Arthritis:
Ulcers:	Reflux:
Kidney Dis.	Blood Disease:
Other:	Heart Disease:
Cancer:	
Testicular/Cervical:	
Breast:	
Colon:	
Brain:	
Lung:	
Other:	

How did you hear about the Rosipal Institute? _____

Patient Signature: _____ Date: _____

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PELVIC FLOOR DISTRESS QUESTIONNAIRE

Patient Name: _____ Date: _____

Instructions: Please answer all of the questions regarding bowel, bladder or pelvic symptoms over the last 3 months.

How much does it bother you: (IN LAST 3 MONTHS)

1 = Not At All **3 = Moderately**

2 = Somewhat **4 = Quite a bit**

IN THE LAST 3 MONTHS have you experienced:	**How much does it bother you? 1= Not at all .... 4= Quite a bit**
1 Usually experience pressure in the lower abdomen?	☐ 1 ☐ 2 ☐ 3 ☐ 4
2 Usually experience heaviness or dullness in the pelvic area?	☐ 1 ☐ 2 ☐ 3 ☐ 4
3 Usually have a bulge or something falling out that you can see or feel in your vaginal area?	☐ 1 ☐ 2 ☐ 3 ☐ 4
4 Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	☐ 1 ☐ 2 ☐ 3 ☐ 4
5 Usually experience a feeling of incomplete bladder emptying?	☐ 1 ☐ 2 ☐ 3 ☐ 4
6 Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	☐ 1 ☐ 2 ☐ 3 ☐ 4
7 Feel you need to strain too hard to have a bowel movement?	☐ 1 ☐ 2 ☐ 3 ☐ 4
8 Feel you have not completely emptied your bowels at the end of a bowel movement?	☐ 1 ☐ 2 ☐ 3 ☐ 4
9 Usually lose stool beyond your control if your stool is well formed?	☐ 1 ☐ 2 ☐ 3 ☐ 4
10 Usually lose stool beyond your control if your stool is loose?	☐ 1 ☐ 2 ☐ 3 ☐ 4
11 Usually lose gas from the rectum beyond your control?	☐ 1 ☐ 2 ☐ 3 ☐ 4
12 Usually have pain when you pass your stool?	☐ 1 ☐ 2 ☐ 3 ☐ 4
13 Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	☐ 1 ☐ 2 ☐ 3 ☐ 4
14 Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	☐ 1 ☐ 2 ☐ 3 ☐ 4
15 Usually experience frequent urination?	☐ 1 ☐ 2 ☐ 3 ☐ 4
16 Usually experience urine leakage associated with a feeling of urgency, that is , a strong sensation of needing to go the bathroom?	☐ 1 ☐ 2 ☐ 3 ☐ 4
17 Usually experience urine leakage related to coughing , sneezing or laughing?	☐ 1 ☐ 2 ☐ 3 ☐ 4
18 Usually experience small amounts of urine leakage(drops)?	☐ 1 ☐ 2 ☐ 3 ☐ 4
19 Usually experience difficulty emptying your bladder?	☐ 1 ☐ 2 ☐ 3 ☐ 4
20 Usually experience *pain* or *discomfort* in the lower abdomen or genital region?	☐ 1 ☐ 2 ☐ 3 ☐ 4

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PELVIC FLOOR IMPACT QUESTIONNAIRE

Patient Name: _____ Date: _____

Instructions: Some women find that bladder, bowel or vaginal 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 vaginal symptoms or conditions **over the last 3 months.**
Please make sure you **mark an answer in all 3 columns for each question.**

How do these symptoms or conditions affect your :

	Bladder or Urine	***Bowel or rectum***	***Vagina or 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

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PELVIC FLOOR THERAPY QUESTIONNAIRE

Name: _____ Date: _____

Please fill in the following questionnaire to the best of your ability. The therapist will review the answers with you at your appointment.

History

Number of pregnancies _____ Number of vaginal deliveries _____

Birth weight of largest baby _____ Number of cesarean deliveries _____

Number of episiotomies _____ Date of last Pap smear _____

Did you have any trouble healing after delivery?	Y	N
Do you have a history of sexual abuse or trauma?	Y	N
Are you having regular periods/menstrual cycles?	Y	N
Do you have frequent urinary tract infections?	Y	N

Pain

Do you have pain with:

Sexual intercourse	Y	N
Pelvic exam	Y	N
Tampon use	Y	N
Back, leg, groin or abdominal pain	Y	N

Test results

Urodynamics test	Y	N	Results: _____
Cystoscopy	Y	N	Results: _____
Urine test	Y	N	Results: _____
Bowel test	Y	N	Results: _____

Patient Name:_____ Pelvic Floor Therapy Questionnaire Con't

Bladder symptoms:

Do you lose urine when you:

Cough/sneeze/laugh	Y	N	Lift/exercise/dance/jump	Y	N
On the way to the bathroom	Y	N	Have a strong urge to urinate	Y	N
Hear running water	Y	N	Other: _____		

Do you wet the bed	Y	N
Have burning/pain with urination	Y	N
Difficulty starting a stream of urine	Y	N
Strain to empty your bladder	Y	N
Feel unable to empty bladder fully	Y	N
Have a falling out feeling	Y	N
Have pain with a full bladder	Y	N
Have an urgency of urination (a strong urge to urinate)	Y	N
Urinate more than 7 times/day	Y	N

Bowel symptoms

Strain to have a bowel movement	Y	N	Leak/strain feces	Y	N
Include fiber in your diet	Y	N	Have diarrhea often	Y	N
Take laxatives/enema regularly	Y	N	Leak gas by accident	Y	N
Have pain with bowel movement	Y	N			
Have a strong urge to move your bowels	Y	N			

How often do you move your bowels: _____ per day / week?

Most common stool consistency:

_____ liquid _____ soft _____ firm _____ pellets _____ other: _____

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PELVIC FLOOR CONSENT FOR EVALUATION & 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 condition, 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. _____ (initial)
2. I understand that I can terminate the procedure at any time. _____ (initial)
3. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation. _____ (initial)
4. I have the option of having a second person present in the room during the procedure and _____ choose _____ refuse this option. _____ (initial)

Date:_____ Patient Name:_____

_____ _____

Patient Signature Signature of Parent or Guardian (if applicable)

_____

Witness Signature

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AUTHORIZATION OF USE/DISCLOSURE OF PROTECTED INFORMATION

Preferred Method of Contact

How would you prefer to be contacted regarding appointments, and/or other information pertinent to your healthcare and/or payment for service provided by the Rosipal Institute for Pelvic Therapy Solutions? (Check all that apply)

- ☐ **Home Phone/voicemail(_____) _____ - _____**
- ☐ **Cell # (_____) _____ - _____**
- ☐ **Work #(_____) _____ - _____**
- ☐ **Email** _____

OK TO LEAVE VOICE MESSAGE-(CIRCLE ONE) **YES*** OR **NO**

OK TO SEND TEXT MESSAGE AND EMAILS - (CIRCLE ONE) **YES*** OR **NO**
*Typically messages are general in nature, and do not mention nature of visit or any specific patient data.

Other Uses and Disclosures: Disclosure of your health information or its use for any purposes other than those listed in the "Notice of Privacy Policies and Practices "consent will require your specific authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke will not affect or undo any disclosure prior to your notification date. You have the right to request restrictions on use and disclosure of your health information.
Please list any restrictions below: _____

PERSONS AUTHORIZED TO RECEIVE INFORMATION:

_____
Name of person/relation to patient Phone #

_____
Print Patient Name

_____
Signature of Patient Date

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FINANCIAL POLICY STATEMENT

IMPORTANT INFORMATION PLEASE READ

The Rosipal Institute has adopted the following financial policy. If after reading this you still have questions, please discuss them with our office manager prior to your first appointment.

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

FINANCIAL POLICY

All patients must read and sign this form prior to receiving services.

- **It is your responsibility to provide us with your most current insurance information.**
- Before receiving services, you must verify that we are participating providers for your insurance company. In the event we are not participating providers with your insurance company, we will file the claim as a courtesy. Payment for services not covered by your out-of-network insurance benefits is your full responsibility.
- If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
- We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
- We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company.**
- It is also necessary that you provide us with your primary care physician information, as listed with your insurance company, even if that is not the doctor referring you to therapy.
- We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full remaining balance, as determined by your insurance company, once they have paid your claim – regardless of our estimation.
- **It is your responsibility to provide us with your most current billing information.**
- You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.

- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30-days after receipt of the initial statement. You can call (972)735-0920.

- **Payment in full is due upon receipt of the statement**. Patient balances not paid in full within 30 days of the statement issue date are deemed past due**. Past due accounts may be subject to a $5.00 monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity**. You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.

- If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.

- If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from Rosipal Institute for Pelvic Therapy Solutions. Failure to accept this certified letter (and/or to pick it up at the post office) serves as notice of termination of services.

- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $25 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.

- **We may charge you a "No Show" fee of $75 if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.**

- **Failure to keep your account balance current may require us to cancel or reschedule your appointment**

I have read and understand this financial policy and agree to abide by its terms. I also understand this policy may be amended from time to time by the Rosipal Institute, with written notice provided to me.

_____

Signature of Patient Date

_____

Printed Name of Patient

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Rosipal Institute for Pelvic Therapy Solutions to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to Rosipal Institute for Pelvic Therapy Solutions. I understand that I am ultimately responsible for all services whether covered by insurance or not. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____

Signature of Patient Date

Rosipal Institute

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____

Print Patient Name

_____

Signature of Patient Date

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