Pelvic Health Center of Santa Barbara

Dear New Patient,

We are excited to get started on your care. Enclosed you will find several pages of forms, including:

- **Patient Agreement**: including policies and fees for the practice. Please take your time to read over it.
- **Intake Form**: This is the place where we learn everything about your condition, your lifestyle, and how this has been affecting you. The more thorough, the better. Your intake will be carefully read twice before your first visit, so we are not asking questions you have already carefully answered. If you are uncomfortable typing and emailing this form, you may mail it to 3902 State Street, Suite 103 Santa Barbara, CA 93105. Our email is HIPPAA compliant, but we cannot guarantee that your email is. If you would rather print, fill out, and mail the form, you may.
- **HIPPAA Form**
- **Communication form and preferences**

We request you to fill out your intake forms and either email them to office@pelvichealthsb.com or to mail them to our office so they reach us 2 business days before your evaluation date. This gives our pelvic health therapists due time to fully read through your intake in preparation for your visit.

If this is not possible for you, you may fill them out at our office. But you must come 45 minutes before your appointment if you choose to do so. If you fill out your intake forms at our office, please be aware that your pelvic health therapist will not be fully prepared for your visit.

Patient Agreement: Pelvic Health Center of Santa Barbara

At Pelvic Health Center of Santa Barbara we are committed to providing you with the best possible pelvic health therapy care. The following policies allow us to provide optimal care for all of our patients.

Payment is due at the time of service. Cash, Check, or Cards are accepted forms of payment. Rates as of January 1, 2020.

- **First evaluations, as well as all follow up visits, are $200 per hour for Dhara and $150 for Elle and Laura.** Please not that you will be asked to arrive 10 minutes before your appointment begins. Arriving early will allow us to use all of our time together for your care. Your time is reserved for 55 minutes after the start of your treatment time. If a patient arrives late, they will be charged for the time that was reserved for them. Our pelvic health therapists will not see a patient past their 55 minute mark, even if a patient has arrived late.

- Prior to your evaluation, you will fill out this paperwork. Your pelvic health therapist will review it once we receive it and then again a day before your visit. At your first visit, your pelvic health therapist will clarify any questions that they had while reading your intake. We will do a very thorough evaluation and spend the remainder of your time on treatment.

- Insurance Forms: If requested, we will provide you with a super bill with diagnosis codes and billing codes that you can send into your insurance provider for possible reimbursement. We cannot guarantee that your insurance company will refund you any of what you have spent at our office, but many of our patients have had great success with this. Our office will not submit the super bill directly to your insurance company. You may also use an HSA account to pay for your visits.

Medicare patients: You will be required to sign a form (ABN) agreeing not to submit charges to Medicare and requesting that we do not. Because Medicare does not cover the care methods, treatment duration, diagnoses we treat, chronic issues, visceral or neural mobilization, or wellness care, Pelvic Health Center has terminated its Medicare Number and has no reimbursement relationship with Medicare. Please let us know if you would like us to recommend a Medicare provider for you. It is our preference to refer Medicare patients to Medicare approved facilities and providers, so they may utilize their benefits.

Potential Benefits: Most patients are very pleasantly surprised at the rapid resolution of symptoms or their increased function. You may experience improvement in your symptoms, improved mobility, function, or feelings of general physical and emotional health. You may experience improved knowledge of your condition, improved self-management, or decreased pain and dysfunction.

No Warranty: Pelvic health therapy is an art and a science of trial and error. No two patients are the same and we cannot guarantee a certain number of visits will produce any certain outcome. Healing is a complex, multifactorial, individualistic response that involves several factors. Pelvic Health Center is but one of the factors in your healing as well as proper diet, exercise, spiritual fitness, mental wellness, healthy relationships, and the rest of your medical team. The patient understands that the pelvic health therapist cannot make any promises or guarantees regarding a cure or improvement of physical conditions. You agree that the therapist will share with you their opinions regarding potential results of pelvic health therapy for your condition and will discuss all treatment options with you. This is a voluntary relationship between two parties. If at any time you are dissatisfied with your care, please let your pelvic health therapist know immediately.

Potential Risk: You may have an increase in symptoms as your body accommodates. This is usually temporary and not typically the case. You agree to let your pelvic health therapist know if the treatment is painful as we seek to avoid pain during your session - this communication is essential. You agree to contact your physician or seek emergent care if you have any severe symptoms as Pelvic Health Center is not a primary or emergent care provider.

As a Patient you agree:

1. To have seen a physician for this condition, whom we can send a script to for signatures. If you are coming for wellness care, we still require you to be seen by another primary care provider who can sign a care plan: MD, DO, DC, or ND. We are not able to detect issues such as cancer, tumors, endometriosis, hormonal imbalance, cardiac disease, bony abnormalities/pathology of organic disease processes from physical therapy evaluation. This will fall under the realm of your primary care.

2. You agree to come to sessions on time, pay at the start of each session, attend scheduled appointments, and actively participate in your recovery by working on your home program towards lifestyle changes we are discussing in pelvic health therapy. Completing your intake form thoroughly is the first step of investing in your care.

3. Voluntary termination of care: You may decide to terminate care or ask for my help to find another provider at any time. Similarly, your therapist reserves the right to terminate care without any explanation at any time.

4. Internal and Pelvic Work: You understand that to evaluate and treat your condition, it may be necessary or optimal to do internal and pelvic muscle exams and manual therapy. This does not substitute for exam from a licensed physician. Internal and pelvic techniques will only be performed after consent prior to each technique, and only as pertaining to your therapy goals and functional outcomes. An explanation of the techniques will be given prior to each technique and consent obtained prior to each technique. As the patient, you hold the responsibility to inform the therapist of any conditions that would limit or prohibit your ability to have an internal examination. Even after giving consent for evaluation and treatment, you have the right to change your mind and clearly ask the treatment to be stopped. The focus of internal and pelvic work is to resolve urinary, bowel, bladder, sexual, neural, or pain issues within the pelvis by addressing fascia, pelvic muscle, visceral-fascial and neural relationships. This practice treats sexual dysfunction, such as anorgasmia, erectile dysfunction, pain with intercourse, or other dysfunctions within the scope of pelvic therapist. The treatment may include direct work to the genitals, which will only be done after explaining the technique to the patient. Though techniques and functional goals may involve sexual function, the patient understands the relationship between the client and physical therapist is strictly professional and non-sexual relationship. If at any time confusion arises as to the nature of the relationship, the therapist should be notified and treatment will be terminated immediately.

Patient Name: _____ Patient DOB: _____

Signature: _____

PATIENT INFORMATION

Patient Name (first, middle, last): _____

Date of Birth: _____

Sex (circle): Male / Female / Male Transgender / Female Transgender / Gender Variant - Non conforming / Other / Not Listed: _____

Street Address:_____

Employer: _____ Occupation: _____

Cell: _____ Alternate: _____

May we text you? (Y/N): _____

Email: _____

In Emergency Notify: _____ Phone: _____ Relationship: _____

How did you hear find us? _____

_____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

What is the primary concern you are seeking treatment for?

_____

_____

When did the problem begin?

_____

_____

_____

What is your goal with therapy?

_____

_____

When did this problem begin? (specific date if possible)

_____

Has the problem worsened in the past year? When?

_____

_____

Who have you seen for this condition in the past year?

_____

Please list medications/supplements and doses including the reason you are taking each medication:

Name	Dose	Reason Taking

Height: _____ Weight: _____

As you fill out the enclosed form, please include EVERYTHING. Not just your pelvic health. We treat holistically, so the car accident 10 years ago, the achy shoulder that still bothers you, the difficulty focusing, poor sleep, these are all very important to us. Please write down a chronological history of what is bringing you in today. Starting from the beginning or any lingering health issues or challenges you've had. The more detailed and comprehensive this is, the more time we will have to treat you at your first visit. If you have had falls, trauma, car accidents, sports injuries, periods of depression or anxiety, etc. Please include any fertility struggles. Take time and be thorough. Use an extra sheet of paper if necessary.

_____

_____

_____

_____

_____

_____

_____

List all surgical procedures you have had, with the year of operation. This includes hernia, appendix, gall bladder, orthopedic, vascular, heart, bowel, c-section, exploratory laps, etc. Please include any complications with this surgery or your recovery. Include body region, surgery type, and date.

_____

_____

_____

_____

What have you done to manage your condition: Specialists, medications, home program, etc?

_____

_____

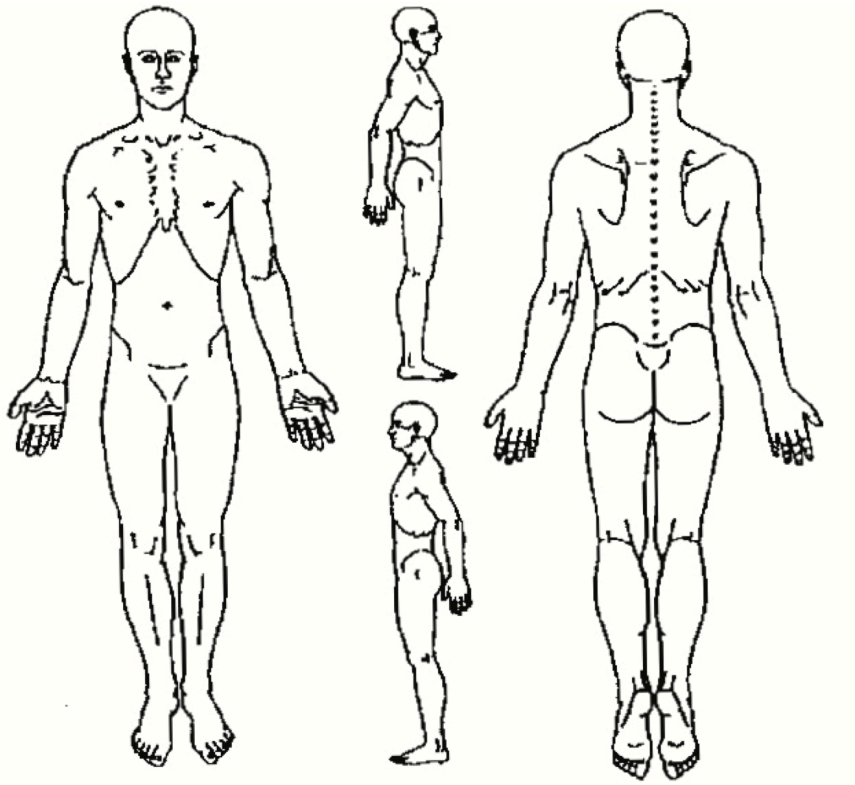
_____

Pain Scale: At worst (1-10) _____ At best: (1-10) _____ Right now (1-10): _____

Type of Pain (please circle all that apply): sharp, acute, dull, chronic, numbing, tingling, other:

_____

Location of Pain (please circle all that apply):



Please circle any of the following that applies to you, then explain in the blank lines that follow:

Heart Attack	Depression	Diabetes	Autoimmune issues
Stroke	Thyroid Issues	High/Low Blood Pressure	Fibromyalgia
Blood Clot	PCOS	Kidney problems	Systemic infection/ sepsis
Chronic Fatigue	Rheumatoid arthritis	Stomach problems	Endometriosis
Gall Bladder Issues	Irritable Bowel	Unintentional weight gain/loss	Seizures
Back Pain	Anemia	Memory problems	Nerve problems
Depression	Bone Fractures	Vision problems	Neuropathy
HIV/AIDS	Bipolar	Cancer	Disc problems
MERS	Chemical Dependence	Excessive bleeding	GERD/Reflux
Anxiety	Alcohol abuse	Diarrhea	Headaches/migranes
Asthma	Chronic constipation	Stool leakage	Lung problems

Explain:

_____

_____

_____

How has your work affected your condition? How?

_____

_____

How would you describe your overall health?

_____

_____

_____

Please describe your typical diet:

_____

_____

What are you actively doing on a regular basis to improve your health and care for yourself?

_____

_____

How much and what type of exercise do you do? Please list all types of exercise:

_____

_____

How do you achieve stress reduction?

_____

_____

Is it working? (yes/no): _____

Would you like to learn more ways to improve your mind/body relationship?

_____

_____

Many patients come for pelvic concerns, so there will be specific questions to that regard in the next section. If you are coming for other issues (nerve pain, hip displacement, etc.) please scan over the urinary questions to see if any apply to you. If a question does not apply to you, please write N/A.

URINARY QUESTIONS

How much water do you drink in 24 hours on average? _____

How much caffeine do you drink? What kind? _____

What else do you drink? How much? _____

How many times during the day do you urinate? _____ At night? _____

When you feel the urge to go, how strong is the urge? (Circle all that apply)

Urgent / High Priority / Moderate Urge / Mild Urge / No Big Deal

How long can you hold urine from the time of the first urge? _____

Do you ever leak urine while: coughing/sneezing/on the way to the restroom/hear water running/ exercising/jumping/laughing/lifting something (Circle all that apply)

Do you use pads? And if so, how many in 24 hours:

_____

_____

Do you have any pain with urination? If so, where and when? (filling, empty, after, etc.)

_____

Do you have difficulty starting a stream of urine? _____

Do you strain to empty your bladder? _____

After you urinate, do you feel fully empty? _____

Do you urinate more than 7 times per day? _____

Do you use a form of leakage protection? _____

Do you restrict your fluid intake? _____ Does your stream start and stop? _____

What else would you like me to know about your urination? Including any stress associations

_____

Bowel History

How often do you have a bowel movement?

_____

Are they (circle): Hard / Soft / Formed / Liquid / Completely Varied

Does it pass easily? _____ Explain: _____

What do you do to stay regular? _____

Do you have pain anywhere before, during, or after your BM's?

_____

When you feel the urge to go, can you hold it? _____ How long? _____

Do you ever leak stool or find smears in your underwear? _____

Do you have diarrhea often? _____

Do you have constipation? _____

Do you take anything to assist in bowel movement? If so, please list all:

_____

_____

<u>All Patients</u>

We are very open and accepting of all expressions of sexuality and gender.

Are you currently sexually active? (Partner/self stimulation/varied/ please explain)

_____

_____

_____

Do you have pain with intercourse/physical intimacy? Explain.

_____

_____

Do you have any pain with orgasming? Explain.

_____

_____

Do you find medical exams or tampons uncomfortable?

_____

Is your sex life satisfying and enriching your life? _____ Do you wish to change that?

_____

If you could change one thing about your sex life what would it be?

_____

_____

_____

_____

Women Only / Post Partum

	Baby #1	Baby #2	Baby #3	Baby #4
Type of birth:	_____	_____	_____	_____
Full Term?	_____	_____	_____	_____
How large was the baby?	_____	_____	_____	_____
Labor Time:	_____	_____	_____	_____
How long did you push?	_____	_____	_____	_____
Complications:	_____	_____	_____	_____
When did you get your first period after birth?	_____	_____	_____	_____

What was the age of your first menses? _____ Do you still have a monthly flow? _____

Are your periods painful? _____

Do you have digestive issues with your cycle? _____

Do you have pain or symptoms with ovulation or during menses? _____

_____

Men Only

Please make sure you have discussed any history of prostatitis, hernia, or trauma to the pelvis. Also, any abdominal or low back issues. If you have had a prostatectomy, please include the details of that and any other treatments you have had. What else would you like us to know about your pelvic health?

_____
_____
_____
_____
_____

General Health Questions

How do you feel about your energy level? _____

_____

When you think of your health, how do you feel? (optimistic, guarded, worried, weary, hopeful, inspired, resigned): _____

_____

What would change that feeling? _____

_____

Are you sensory sensitive? Do any of the following bother you? If so, please explain what you feel in those situations.

- Louder background sounds
- Walking through the detergent section at a store
- Clothing with tags or scratchy material
- Household noice when you are sleeping
- Chemicals in food
- Perfumes

- Environmental allergies
- Food intolerances
- Shoes, walking barefoot, or trimming toenails

Explain:

_____
_____
_____

What else should we know?

_____
_____
_____
_____
_____
_____

All Patients Please Sign and Date:

Patient Signature: _____ Date: _____

Patient Printed Name: _____

Pelvic Health Center of Santa Barbara

Cancellation/Rescheduling/No Show Policies

Pelvic Health Center is committed to providing all of our patients with exceptional one-on-one care. When a patient cancels without advanced notice, it prevents the possibility of another patient taking his or her place on the schedule. We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable, however, advance notification allows us to fulfill other patients scheduling needs and keeps the facility operating at its best.

1. **Cancellation/Rescheduling**: Please call us 24 hours, on the business day, *prior* to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 3:00pm on *Friday*. Patients who do not call to cancel or reschedule their appointment before the time frames provided will be charged a $200.00 for a missed appointment with Dhara, $150 for a missed appointment with either Elle or Laura cancellation fee, and $100 for a missed appointment with Ilan. **Initials**:_____

2. **If the Appointment is Filled:** If you call and cancel your appointment, outside of the provided time frames above, and we *fill* the appointment with another patient, you will not be charged a cancellation fee. **Initials: _____**

3. **No Show**: If you do not show up for a scheduled appointment, you will be charged either $150 or $200.00 no show fee, depending on your pelvic floor therapist. **Initials**: _____

4. After missing two appointments without any notice, you may be placed on a same week scheduling policy for your treatments, which would not allow you to schedule any appointments in advance. **Initials**: _____

5. You will be responsible for any charges that arise, as we cannot bill your insurance for missed appointments. You will be required to pay any charges on or before your next scheduled appointment. **Initials**: _____

We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and service to everyone. All of the staff at Pelvic Health Center of Santa Barbara appreciate your anticipated adherence and cooperation with this policy. We are here to help you attain all of your goals and optimize your return to all of your pre-injury activities.

By signing below, you acknowledge that you have read and you understand the Cancellation/ Rescheduling/No Show for Pelvic Health Center as described as above.

_____

Signature and Date

_____

Printed Name

Pelvic Health Center of Santa Barbara

Consent for Purposes of Treatment, Payment, and Health Care Operations

I consent to the use or disclosure of my protected health information by **Pelvic Health Center of Santa Barbara** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Pelvic Health Center of Santa Barbara**.

I understand that diagnosis or treatment of me by **Pelvic Health Center of Santa Barbara** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. **Pelvic Health Center of Santa Barbara** is not required to agree to the restrictions that I may request. However, if **Pelvic Health Center of Santa Barbara** agrees to a restriction that I request, the restriction is binding at **Pelvic Health Center of Santa Barbara**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Pelvic Health Center of Santa Barbara** has taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Pelvic Health Center of Santa Barbara's** notice of Privacy Practices prior to signing this document.

The **Pelvic Health Center of Santa Barbara's** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Pelvic Health Center of Santa Barbara**. The Notice of Privacy Practices also describes my rights and the duties of **Pelvic Health Center of Santa Barbara** with respect to my protected health information.

Pelvic Health Center of Santa Barbara reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revives copy be sent in the mail or ask for one at the time of my next appointment.

_____

Signature of Patient or Personal Representative

_____ _____

Name of Patient or Personal Representative Date