PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

I understand that if I am referred to physical therapy for pelvic floor dysfunction, it may beneficial for my therapist to perform a muscle assessment of the pelvic floor, initially and periodically to assess muscle strength, length, and range of motion and scar mobility. Palpation of these muscles is most direct and accessible if done via the vagina and/or rectum. Pelvic floor dysfunctions include: pelvic pain syndromes, urinary incontinence, fecal incontinence dyspareunia or pain with intercourse, pain from an episiotomy or scarring, vulvodynia, vestibulitis or other complications. Evaluation of my condition may include observation, soft tissue mobilization, use of vaginal cones, and vaginal or rectal sensors for biofeedback and/or electrical stimulation.

I understand that the benefits of the vaginal/rectal assessments will be explained to me. I understand that if I am uncomfortable with the assessment or treatment procedures **AT ANY TIME**, I will inform my therapist and the procedure will be discontinued and alternatives will be discussed with me.

Treatment procedures for pelvic floor dysfunctions include without limitation: education, exercise, stimulation, ultrasound, use of vaginal weights, and several manual techniques including massage, joint and soft tissue mobilization. The therapist will explain all of these treatment procedures to me and I may choose to not participate with all or part of the treatment plan. I understand that no guarantees have been or can be provided to me regarding the success of therapy.

I have read or had read to me the foregoing and any questions, which may have occurred to me, have been answered to my satisfaction. I understand the risks, benefits, and alternatives of the treatment.

Based on the information I have received from the therapist, I voluntarily agree to standard assessment and muscular treatment techniques of the perineal area.

☐ I am comfortable with only the therapist performing the evaluation in the room

☐ I would prefer to have a chaperone in the room while the therapist performs the evaluation.

Patient Signature and Date Therapist Signature and Date

Patient's Legal Representative/Guardian/Parent Relationship to Patient

*** If you are pregnant, have an infection of any kind, have vaginal dryness, are less than 6 week postpartum or post surgery, have severe pelvic pain, sensitivity to KY Jelly, vaginal creams or latex, please inform the therapist prior to pelvic floor assessment.

PERSONAL INFORMATION

PLEASE COMPLETE ALL SECTIONS			
NAME		HOME PHONE	CELL PHONE
ADDRESS		CITY	ZIP CODE
EMPLOYER		MARITAL STATUS	SEX
BIRTHDATE	DO YOU HAVE A REFERRAL?	REFERRING PHYSICIAN:	
EMERGENCY CONTEACT NAME		PHONE	RELATIONSHIP

DATE OF RECENT INJURY OR WORSENING OF SYMPTOMS:	BODY AREA BEING TREATED/DIAGNOSIS:
ARE YOU CURRENLTY RECEIVEING HOME HEALTH SERVICES?	AVERAGE PAIN LEVEL (0-10)
ANY UPCOMING PROCEDURES OR PHYSICIAN VISITS?	WHAT IS YOUR GOAL FOR THERAPY?

EMAIL ADDRESS (We use this to send your home exercise lists and pictures):

_____

Is your injury at all related to a motor vehicle accident or work injury? ____Yes ____No

If yes, do you already have an attorney group you are working with? ____Yes ____No

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MEDICAL HISTORY

What are you being seen for today? _____

Do you feel you understand your diagnosis? _____

Has a medical provider given you any exercise restrictions: ☐ yes ☐ no
If yes, please explain: _____

Are you currently engaged in any form of exercise: ☐ yes ☐ no
If yes, please explain: _____

Are you currently working full duty: ☐ yes ☐ no
If no, please list any limitations: _____

If you are not working due to your injury, when do you anticipate returning to work: _____/_____/_____

Do you now have or have you ever had any of the following?

- ☐ Allergies
- ☐ Asthma/Bronchitis/Breathing Restriction
- ☐ Emphysema/Shortness of Breath Chest Pain
- ☐ Coronary Heart Disease or Angina High
- ☐ Blood Pressure
- ☐ Heart Attack or Heart Surgery Stroke
- ☐ Congestive Heart Failure
- ☐ Blood Clot/Emboli
- ☐ Varicose Veins

- ☐ Thyroid Disease or Goiter
- ☐ Anemia
- ☐ Infectious Disease (HIV, Hepatitis, etc)
- ☐ Diabetes Type 1 or 2
- ☐ Low or High Blood Sugar
- ☐ Kidney or Liver Problems
- ☐ Cancer
- ☐ Mastectomy

- ☐ Arthritis
- ☐ Osteoporosis/Osteopenia
- ☐ Gout
- ☐ Fibromyalgia/Chronic Pain
- ☐ Anxiety/Depression
- ☐ Sleep Problems
- ☐ Spinal Stimulator

- ☐ Severe or Frequent Headaches
- ☐ Visual or Hearing Difficulties
- ☐ Dizziness or Fainting
- ☐ Epilepsy/Seizures
- ☐ Bowel or Bladder Problems/Weakness
- ☐ Weight Loss or Gain/Fatigue
- ☐ Difficulty Swallowing
- ☐ Drooping Eye Lid

- ☐ Hernia
- ☐ Are Pregnant
- ☐ Hysterectomy
- ☐ Nausea/Vomiting

- ☐ Any pins or metal implants
- ☐ Shoulder Injury or Surgery
- ☐ Neck Injury or Surgery
- ☐ Joint Replacement Surgery
- ☐ Elbow/Hand Injury or Surgery
- ☐ Back Injury or Surgery
- ☐ Knee Injury or Surgery
- ☐ Leg/Ankle Injury or Surgery

- ☐ Recent Trips or Falls

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MEDICAL HISTORY

Please elaborate on any major medical condition checked above:

_____

_____

Please list any other medical conditions, surgery, or information you'd like us to know:

_____

_____

Please list all current medications or provide us a copy:

_____

_____

Have you had any of the following Medical Treatments or Testing:

- ☐ Physical Therapy
- ☐ Acupuncture
- ☐ Chiropractic
- ☐ Massage
- ☐ Emergency Room Care
- ☐ X-Ray
- ☐ CT Scan
- ☐ MRI
- ☐ Bone Scan
- ☐ Ultrasound

Please elaborate on the outcome of your treatment or testing if checked above:

_____

_____

What is your biggest question or concern regarding your pain or injury for our therapists to address today:

_____

_____

I certify that the above personal and medical information is complete and accurate to the best of my knowledge. I understand and agree to the Consent To Be Recorded and Consent For Treatment.

_____ _____

SIGNATURE DATE

_____ _____

PARENT OR GUARDIAN (IF MINOR) DATE

CLEARCUT ORTHO, LLC
CANCELLATION / NO-SHOW POLICY

The no-show/cancellation policy is enforced for the following reasons:

1. We rely heavily on our schedule to maintain a high standard of care.
2. By giving appropriate notice to the facility, we are able to offer your appointment slot to other patients.
3. Repeated cancellations will slow your progress and likely prevent you from experiencing optimal outcomes from treatment.

Any patient who cancels with less than 24 hours notice or fails to show up for a visit will be charged a $50.00 cancellation fee which must be paid to continue therapy.

After 3 late cancellations or no-shows, you will be discharged from therapy and your referring physician notified that the plan of care was unable to be completed.

I agree to the No-Show and Cancellation Policy:

_____ _____
Name Date

CLEARCUT ORTHO, LLC
POLICIES AND CONSENTS

CONSENT FOR TREATMENT:

I consent and authorize ClearCut ORTHO, LLC to provide physical therapy services to myself or my dependent, that may be considered appropriate upon the professional judgment of my treating therapist, and/or my referring physician. I also understand that I have the right to ask, and have any questions answered prior to, during, and after treatments and examinations. This includes risks, benefits, alternatives, and purpose of tests/treatments. I understand that under the supervision of my physical therapist, treatment and evaluation may include; electrical stimulation, dry needling, spinal manipulation, ultrasound, laser treatment, joint mobilizations, therapeutic exercise, moist heat, iontophoresis, traction, ice, paraffin, soft tissue mobilization, neuromuscular re-education, diagnostic ultrasound, and electromyography. I understand that my physical therapist will utilize such testing and interventions as he/she deems appropriate to my care.

CONSENT TO RELEASE/ OBTAIN MEDICAL INFORMATION:

Permission is hereby granted to ClearCut ORTHO, LLC to release any and all pertinent PHI information to me, my insurance company, employer, attorney, workers compensation carrier, physician/facility referred to for further treatment and/or my referring/family physician. **Permission is hereby granted to any facility where I have previously been treated to release medical records to ClearCut ORTHO, LLC.**

Please list below any other individuals you would like to have authorization to access your information:
Name:_____ Relationship:_____ DOB:___/___/_____

FINANCIAL POLICY STATEMENT:

I authorize ClearCut ORTHO, LLC to bill my health insurance for services rendered. All payments received will be applied to my balance. I will be responsible for all co-pays/co-insurance and deductibles that may apply. Although ClearCut ORTHO, LLC will help verify and assist me in understanding my benefits, it is ultimately my responsibility and I will not hold ClearCut ORTHO, LLC responsible for any misinterpretation of insurance benefits. I understand that any charges not paid by my insurance company are my responsibility, and are due and payable by me. We have prepared a detailed **FINANCIAL POLICY STATEMENT** to help you better understand our policies in regards to your personal health information. The terms of the Financial Statement may change with time and we will always post the current notice at our facility as well as have copies available for distribution if requested. The undersigned acknowledges understanding of this information.

INFORMATION PRIVACY STATEMENT:

ClearCut ORTHO, LLC will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies in regards to your personal health information. The terms of the Privacy Statement may change with time and we will always post the current notice at our facility as well as have copies available for distribution if requested. The undersigned acknowledges understanding of this information.

CONSENT TO BE RECORDED:

I hereby give my permission for ClearCut ORTHO, LLC to videotape or photograph me performing exercises or movements on any company device or on my own personal devices. I understand that all pictures or videos on company devices are considered private HIPAA protected information and will not be used in any means or format without written consent from the patient. Recordings on company devices may be to give feedback on biomechanics and movement patterns. Many times the patient uses the recordings on their own cellular devices to enhance understanding of their home exercise program. I understand that I may decline recordings at any time.

I understand and agree to the Consent To Release/Obtain Medical Information, Financial Policy Statement, Information Privacy Statement, Consent To Be Recorded, and Consent For Treatment statements above. I acknowledge that I have received copies of the Financial Policy and Privacy Policy:

_____ _____
SIGNATURE DATE

_____ _____
PARENT OR GAURDIAN (IF MINOR) DATE

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DRY NEEDLING CONSENT & INFORMATION FORM

What is Dry Needling?

Dry Needling is a form of therapy in which fine needles are inserted into myofascial trigger points (painful knots in muscles), tendons, ligaments, or near nerves in order to stimulate a healing response in painful musculoskeletal conditions. Dry needling is not acupuncture or Oriental Medicine; that is, it does not have the purpose of altering the flow of energy ("Qi") along traditional Chines meridians for the treatment of diseases. In fact, dry needling is a modern, science-based intervention for the treatment of pain and dysfunction in musculoskeletal conditions such as neck pain, shoulder impingement, tennis elbow, carpal tunnel syndrome, headaches, knee pain, shin splints, plantar fasciitis, or low-back pain.

Is Dry Needling Safe?

Drowsiness, tiredness or dizziness occurs after treatment in a small number of patients (1-3%) and if affected, you are advised not to drive. Minor bleeding or bruising occurs after dry needling in 15-20% of treatments and is considered normal. Temporary pain during dry needling occurs in 60-70% of treatments. Existing symptoms can get worse after treatment (less than 3% of patients); however, this is not necessarily a "bad" sign. Fainting can occur in certain patients (0.3%), particularly at the first treatment session when needling the head or neck regions. Dry needling is very safe; however, serious side effects can occur in less than 1 per 10,000 (less than 0.01%) treatments. The most common serious side effect from dry needling is pneumothorax (lung collapse due to air inside the chest wall). The symptoms of dry needling-induced pneumothorax commonly do not occur until after the treatment session, sometimes taking several hours to develop. The signs and symptoms of a pneumothorax may include shortness of breath on exertion, increased breathing rate, chest pain, a dry cough, bluish discoloration of the skin, or excessive sweating. If such signs and/or symptoms occur, you should immediately contact your physical therapist or physician. Nerves or blood vessels may be damaged from dry needling which can result in pain, numbness or tingling; however, this is a very rare event and is usually temporary. Damage to internal organs has been reported in the medical literature following needling; however, these are extremely rare event (1 in 200,000).

Is there anything your practitioner needs to know?

1. **Have you ever fainted or experienced a seizure?** **YES / NO**
2. **Do you have a pacemaker or any other electrical implant?** **YES / NO**
3. **Are you currently taking anticoagulants (blood-thinners e.g. Warfarin, Coumadin)?** **YES / NO**
4. **Are you currently taking antibiotics for an infection?** **YES / NO**
5. **Do you have a damaged heart valve, metal prosthesis or other risk of infection?** **YES / NO**
6. **Are you pregnant or actively trying for a pregnancy?** **YES / NO**
7. **Do you suffer from metal allergies?** **YES / NO**
8. **Are you a diabetic or do you suffer from impaired wound healing?** **YES / NO**
9. **Do you have hepatitis B, hepatitis C, HIV, or any other infections disease?** **YES / NO**
10. **Have you eaten in the last two hours?** **YES / NO**

- **Only single-use, disposable needles are used in this clinic.**

STATEMENT OF CONSENT

I confirm that I have read and understand the above information, and I consent to having dry needling treatments. I understand that I can refuse treatment at any time.

Signature: _____ Date: _____