Rehab Partners, Inc.
Health History Questionnaire Date_____

PLEASE NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Name: _____ DOB: _____ Age: _____

What medical concerns bring you to our office? _____

How did you hear about our office? ☐ Doctor ☐ Friend/Family ☐ Advertisement ☐ Web ☐ Insurance

If disabled, check here: ☐ Nature of disability: _____

Do you exercise routinely? *(circle)* Yes No If yes, what exercise/how often? _____

Have you used tobacco products one or more times within the last 24 months? (circle) Yes No
If yes, was cessation counseling intervention received? (circle) Yes No

Have you completed Advanced Directives or do you have a Living Will? *(circle)* Yes No Which? _____

Tell us about your home environment: *(e.g. live alone or with family; house or apt; stairs? pets?)*

_____

Have you had 2 or more falls in the past year, or any one fall with injury in the past year? (circle) Yes No

Medical Information:

Allergies: _____

Have you ever been diagnosed with or treated for the following conditions? Check all that apply:

☐ Pacemaker	☐ Heart Attack	☐ High Blood Pressure	☐ Diabetes	☐ Stroke/TIA
☐ High Cholesterol	☐ Osteoporosis	☐ Rheumatoid Disease	☐ Osteoarthritis	☐ Seizures
☐ Asthma	☐ COPD	☐ TB/Lung Disease	☐ Pneumonia	☐ Anemia
☐ Thyroid Disease	☐ Lupus	☐ Multiple Sclerosis	☐ Fibromyalgia	☐ HIV/AIDS
☐ Liver Disease	☐ Kidney Disease	☐ Hepatitis A, B or C	☐ Digestive Disorder	
☐ Depression	☐ Anxiety	☐ Glaucoma	☐ Cataracts	

☐ Cancer (please specify type and year diagnosed):_____

PRESCRIPTION MEDICATION:	DOSAGE:	FREQUENCY:	PURPOSE:	ROUTE OF ADMINISTRATION:
OVER-THE COUNTER MEDICATION:	DOSAGE:	FREQUENCY:	PURPOSE:	ROUTE OF ADMINISTRATION:
HERBAL MEDICATION	DOSAGE:	FREQUENCY:	PURPOSE:	ROUTE OF ADMINISTRATION:
VITAMINS/MINERALS/DIETARY SUPPLEMENTS:	DOSAGE:	FREQUENCY:	PURPOSE:	ROUTE OF ADMINISTRATION:

Please list all illnesses, medical conditions and surgeries not discussed above:

_____

_____

_____

Personal Safety: (circle your answer)

Are you under a lot of pressure at work or home? Yes No If yes, which? _____

Do you have any safety concerns? Yes No

Do you have any difficulty obtaining or preparing 2 meals per day? Yes No

****

I certify that I have read and understand the above. I will not hold Rehab Partners, Inc. or any of its staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Patient's/Guardian's signature (or individual completing form for patient) Date

Pelvic Floor Rehab Questionnaire

NAME:

	Yes	No
Do you leak urine when you stand up?		
Do you leak urine when you cough, sneeze or laugh?		
Do you leak urine when you lift objects?		
Do you leak urine when you exercise?		
Do you leak urine when you have a strong urge to urinate?		
Do you leak urine on the way to the bathroom?		
Do you leak urine while putting your key in the door?		
Do you leak urine while trying to undress at the toilet?		
Do you leak urine when you see, hear or feel water?		
Do you have difficulty initiating a urine stream?		
Do you have difficulty stopping your stream?		
Do you have pain or burning during urination?		
Do you have blood in your urine?		
Do you need to strain to empty your bladder?		
Have you ever done exercises to control urine loss (Kegel)?		
Has your doctor prescribed medication to treat urine loss?		
Have you had any surgical procedures to treat urine loss?		

	Yes	No
Straining to defecate		
Incontinence of stool		
Laxative use		
Enemas		
Fiber supplements		
Do you experience pain during sexual activity?		
Do you have pain in the lower abdomen or perineum?		
Do you have low back pain?		
Do you experience heaviness or pressure in your pelvis?		

# of cups per day: Water _____ Carbonated drinks _____ Coffee/tea _____
Acidic drinks _____ Alcoholic drinks _____

On average, how often do you empty your bladder? (circle) every hour or less every 1-2 hours
every 2-3 hours every 3-4 hours more than 4 hours between voids

I wake up to empty my bladder _____ times per night.

How many urinary tract infections do you get per year? _____

How long have you experienced incontinence? _____

What type of protective devices do you use? (circle all that apply): panty liner mini pad
maxi pad incontinence pad/brief

# of pads per day: _____

Frequency of BM: _____ times per week

Number of pregnancies: _____ Live births: _____ C-sections: _____

Have you had an episiotomy? Y N

Pelvic Floor Impact Questionnaire - Short Form 7 (PFIQ-7)

Name _____ Date of Birth _____ Today's Date_____

Height _____ ft. _____ in. **Weight_____lbs.**

Instructions: Some women find that bladder, bowel, or vaginal symptoms affect their activities, relationships, and feelings. For each question, check the response that best describes how much your activities, relationships, or feelings have been affected by your bladder, bowel and vaginal / pelvic symptoms or conditions **over the last 3 months.** Please be sure to mark an answer in **all 3 columns** for each question.

How do symptoms or conditions in the following usually affect your	***Bladder or Urine***	***Bowel or Rectum***	***Vagina or Pelvis***
1. Ability to do household chores (cooking, laundry housecleaning)?	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
Summary Score: 0	UIQ-7: 0	CRAIQ-7: 0	POPIQ-7: 0

Pelvic Floor Distress Inventory (PFDI-20)

Patient Name:_____

Date: _____ **DOB**_____

Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6)	**NO**	**YES**			
		If yes, how much does it bother you?			
	No	**Not at all**	**Somewhat**	**Moderately**	**Greatly**
Do you usually experience *pressure* in the lower abdomen?	0	1	2	3	4
Do you usually experience *heaviness* or *dullness* in pelvic area?	0	1	2	3	4
Do you usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1	2	3	4
Do you ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1	2	3	4
Do you usually experience a feeling of incomplete bladder emptying?	0	1	2	3	4
Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1	2	3	4

Colorectal-Anal Distress Inventory 8 (CRADI-8)	**No**	**Not at all**	**Somewhat**	**Moderately**	**Greatly**
Do you feel you need to strain too hard to have a bowel movement?	0	1	2	3	4
Do you feel you have not completely emptied your bowels at the end of a bowel movement?	0	1	2	3	4
Do you usually lose stool beyond your control if your stool is well formed?	0	1	2	3	4
Do you usually lose stool beyond your control if your stool is loose?	0	1	2	3	4
Do you usually lose gas from the rectum beyond your control?	0	1	2	3	4
Do you usually have pain when your pass your stool?	0	1	2	3	4
Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1	2	3	4
Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1	2	3	4

Urinary Distress Inventory 6 (UDI-6)	**No**	**Not at all**	**Somewhat**	**Moderately**	**Greatly**
Do you usually experience frequent urination?	0	1	2	3	4
Do you usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of need to go to the bathroom?	0	1	2	3	4
Do you usually experience urine leakage related to coughing, sneezing, or laughing?	0	1	2	3	4
Do you usually experience small amounts of urine leakage (that is, drops)?	0	1	2	3	4
Do you usually experience difficulty emptying your bladder?	0	1	2	3	4
Do you usually experience *pain* or *discomfort* in the lower abdomen or genital region?	0	1	2	3	4

Vulvar Pain Functional Questionnaire

Because of my pelvic pain

3 - I can't wear tight fitting clothing like pantyhose that puts any pressure over my painful area.

2 - I can wear closer fitting clothing as long as it only putts a little pressure over my painful area.

1 - I can wear whatever I like most of the time, but every now and then I feel pelvic pain caused by pressure from my clothing.

0 - I can wear whatever I like; I never have pelvic pain because of clothing.

Because of my pelvic pain

3 - Gets worse when I walk, so I can only walk far enough to move around in my house, no further.

2 - Gets worse when I walk. I can walk a short distance outside the house, but it is very painful to walk far enough to get a full load of groceries in a grocery story.

1 - Gets a little worse when I walk. I can walk far enough to do my errands, like grocery shopping, but it would be very painful to walk longer distances for fun or exercise.

0 - My pain does not get worse with walking; I can walk as far as I want to.

0 - I have a hard time walking because of another medical problem, but pelvic pain doesn't make it hard to walk.

Because of my pelvic pain

3 - Gets worse when I sit, so it hurts too much to sit any longer than 30 minutes at a time.

2 - Gets worse when I set. I can sit for longer than 30 minutes at a time, but it is so painful that it is difficult to do my job or sit long enough to watch a movie.

1 - Occasionally gets worse when I sit, but most of the time sitting is comfortable.

0 - My pain does not get worse with sitting. I can sit as long as I want to.

0 - I have trouble sitting for very long because of another medical problem, but pelvic pain doesn't make it hard to sit.

Because of my pelvic pain

3 - I am sleepy and have trouble concentrating at work or while o do housework.

2 - I can concentrate just long enough to do my work, but I can't do more, like going out in the evenings.

1 - I can do all of my work, and go out in the evening if I want to, but I feel out of sorts.

0 - I don't have any problems with the pills that I take for pelvic pain.

0 - I don't take pain pills for my pelvic pain.

Because of my pelvic pain

3 - I have very bad pain when I try to have a bowel movement, and it keeps hurting for at least 5 minutes after I am finished.

2 - It hurts when I try to have a bowel movement, but the pain goes away when I'm finished.

1 - Most of the time it does not hurt when I have a bowel movement, but every now and then it does.

0 - It never hurts from my pelvic pain when I have a bowel movement.

Because of my pelvic pain

3 - I don't get together with my friends or go out to parties or events.

2 - I only get together with my friends or go out to parties or events every now and then.

1 - I usually will go out with friends or to events if I want to, but every now and then I don't because of the pain.

0 - I get together with friends or go to events whenever I want, pelvic pain does not get in the

way.

Because of my pelvic pain

3 - I can't stand for the doctor to insert the speculum when I go to the gynecologist.

2 - I can stand it when the doctor inserts the speculum if they are very careful, but most of the time it really hurts.

1 - It usually doesn't hurt when the doctor inserts the speculum, but every now and then it does hurt.

0 - It never hurts for the doctor to insert the speculum when I go to the gynecologist.

Because of my pelvic pain

3 - I cannot use tampons at all, because they make my pain much worse.

2 - I can only use tampons if I put them in very carefully.

1 - It usually doesn't hurt to use tampons, but occasionally it does hurt.

0 - It never hurts to use tampons.

0 - This question doesn't apply to me, because I don't need to use tampons, or I wouldn't choose to use them whether they hurt or not.

Because of my pelvic pain

3 - I can't let my partner put a finger or penis in my vagina during sex at all.

2 - My partner can put a finger or penis in my vagina very carefully, but it still hurts.

1 - It usually doesn't hurt if my partner puts a finger or penis in my vagina, but every now and then it does hurt.

0 - It doesn't hurt to have my partner put a finger or penis in my vagina at all.

0 - This question does not apply to me because I don't have a sexual partner.

0 - Specifically, I won't get involved with a partner because I worry about pelvic pain during sex.

Because of my pelvic pain

3 - It hurts too much for my partner to touch me sexually even if the touching doesn't go in my vagina.

2 - My partner can touch me sexually outside the vagina if we are very careful.

1 - It doesn't usually hurt for my partner to touch me sexually outside the vagina, but every now and then it does hurt.

0 - It never hurts for my partner to touch me sexually outside the vagina.

0 - This question does not apply to me because I don't have a sexual partner.

0 - Specifically, I won't get involved with a partner because I am worried about pelvic pain during sex.

Because of my pelvic pain

3 - It is too painful to touch myself for sexual pleasure.

2 - I can touch myself for sexual pleasure if I am very careful.

1 - It usually doesn't hurt to touch myself for sexual pleasure, but every now and then it does hurt.

0 - It never hurts to touch myself for sexual pleasure.

0 - I don't touch myself for sexual pleasure, but that is by choice, not because of pelvic pain.

Score: To determine score add numerical values assigned to each response. The higher the score the greater the functional limitation. Diminishing score represents improvement.

Urogenital Distress Inventory

Instructions

Do you experience, and if so, how much are you bothered by:

Frequent Urination?

- No
- Yes

If yes, how much does it bother you?

- Not At All
- Slighty
- Moderately
- Greatly

Night time Urination?

- No
- Yes

If yes, how much does it bother you?

- Not At All
- Slighty
- Moderately
- Greatly

Urine leakage related to the feeling of urgency?

- No
- Yes

If yes, how much does it bother you?

- Not At All
- Slighty
- Moderately
- Greatly

Urine leakage related to physical activity, coughing or sneezing?

- No
- Yes

If yes, how much does it bother you?

- Not At All
- Slighty
- Moderately
- Greatly

General urine leak not related to urgency or activity?

- No
- Yes

If yes, how much does it bother you?

- Not At All

Slighty

Moderately

Greatly

Small amounts of urine leakage (drops)?

No

Yes

If yes, how much does it bother you?

Not At All

Slighty

Moderately

Greatly

Large amounts of urine leakage?

No

Yes

If yes, how much does it bother you?

Not At All

Slighty

Moderately

Greatly

Difficulty emptying your bladder?

No

Yes

If yes, how much does it bother you?

Not At All

Slighty

Moderately

Greatly

Pain or discomfort in the lower abdominal or genital area?

No

Yes

If yes, how much does it bother you?

Not At All

Slighty

Moderately

Greatly

No= 0, Not at all= 1, Somewhat= 2, Moderately= 3, Quite a bit= 4
Obtain the mean value of all the answered items then multiply by 25 for the scale score. Missing items are dealt with by using the mean from the answered items only

---

Continence Grading Scale: A Symptom Index

Incontinence For Solids Stool

0: Never (No episodes in the past 4 weeks)

1: Rarely (1 episode in the past 4 weeks)

2: Sometimes (More than 1 episode in the past 4 weeks but less than once per week)

3: Weekly (1 or more episodes per week but less than daily)

4: Daily (1 or more episodes per day)

Incontinence For Liquids Stool

0: Never (No episodes in the past 4 weeks)

1: Rarely (1 episode in the past 4 weeks)

2: Sometimes (More than 1 episode in the past 4 weeks but less than once per week)

3: Weekly (1 or more episodes per week but less than daily)

4: Daily (1 or more episodes per day)

Incontinence For Gas

0: Never (No episodes in the past 4 weeks)

1: Rarely (1 episode in the past 4 weeks)

2: Sometimes (More than 1 episode in the past 4 weeks but less than once per week)

3: Weekly (1 or more episodes per week but less than daily)

4: Daily (1 or more episodes per day)

Alteration In Lifestyle

0: Never (No episodes in the past 4 weeks)

1: Rarely (1 episode in the past 4 weeks)

2: Sometimes (More than 1 episode in the past 4 weeks but less than once per week)

3: Weekly (1 or more episodes per week but less than daily)

4: Daily (1 or more episodes per day)

Need To Wear Pad Or Plug

0: No

2: Yes

Taking Constipation Medicines

0: No

2: Yes

Lacking The Ability To Defer Defection For 15 Minutes

0: No

4: Yes

Minimum score 0: Perfect Continence
Maximum score: 24: Totally Incontinent

BLADDER RECORD

NAME: _____

DATE: _____

	Urinate in Toilet	Amount of Leak/Accident	Activity During Leak	Drink Type/Amount
6:00 AM				
7:00 AM				
8:00 AM				
9:00 AM				
10:00 AM				
11:00 AM				
12:00 PM				
1:00 PM				
2:00 PM				
3:00 PM				
4:00 PM				
5:00 PM				
6:00 PM				
7:00 PM				
8:00 PM				
9:00 PM				
10:00 PM				
11:00 PM				
12:00 AM				
1:00 AM				
2:00 AM				
3:00 AM				
4:00 AM				
5:00 AM				
TOTAL				

NUMBER OF PADS USED: _____

DATE: _____

	Urinate in Toilet	Amount of Leak/Accident	Activity During Leak	Drink Type/Amount
6:00 AM				
7:00 AM				
8:00 AM				
9:00 AM				
10:00 AM				
11:00 AM				
12:00 PM				
1:00 PM				
2:00 PM				
3:00 PM				
4:00 PM				
5:00 PM				
6:00 PM				
7:00 PM				
8:00 PM				
9:00 PM				
10:00 PM				
11:00 PM				
12:00 AM				
1:00 AM				
2:00 AM				
3:00 AM				
4:00 AM				
5:00 AM				
TOTAL				

NUMBER OF PADS USED: _____

Revised 10.24.19

BLADDER RECORD

NAME: _____

DATE: _____

	Urinate in Toilet	Amount of Leak/Accident	Activity During Leak	Drink Type/Amount
6:00 AM				
7:00 AM				
8:00 AM				
9:00 AM				
10:00 AM				
11:00 AM				
12:00 PM				
1:00 PM				
2:00 PM				
3:00 PM				
4:00 PM				
5:00 PM				
6:00 PM				
7:00 PM				
8:00 PM				
9:00 PM				
10:00 PM				
11:00 PM				
12:00 AM				
1:00 AM				
2:00 AM				
3:00 AM				
4:00 AM				
5:00 AM				
TOTAL				

NUMBER OF PADS USED: _____

DATE: _____

	Urinate in Toilet	Amount of Leak/Accident	Activity During Leak	Drink Type/Amount
6:00 AM				
7:00 AM				
8:00 AM				
9:00 AM				
10:00 AM				
11:00 AM				
12:00 PM				
1:00 PM				
2:00 PM				
3:00 PM				
4:00 PM				
5:00 PM				
6:00 PM				
7:00 PM				
8:00 PM				
9:00 PM				
10:00 PM				
11:00 PM				
12:00 AM				
1:00 AM				
2:00 AM				
3:00 AM				
4:00 AM				
5:00 AM				
TOTAL				

NUMBER OF PADS USED: _____

Revised 10.24.19

BLADDER RECORD

NAME: _____

DATE: _____

	Urinate in Toilet	Amount of Leak/Accident	Activity During Leak	Drink Type/Amount
6:00 AM				
7:00 AM				
8:00 AM				
9:00 AM				
10:00 AM				
11:00 AM				
12:00 PM				
1:00 PM				
2:00 PM				
3:00 PM				
4:00 PM				
5:00 PM				
6:00 PM				
7:00 PM				
8:00 PM				
9:00 PM				
10:00 PM				
11:00 PM				
12:00 AM				
1:00 AM				
2:00 AM				
3:00 AM				
4:00 AM				
5:00 AM				
TOTAL				

NUMBER OF PADS USED: _____

DATE: _____

	Urinate in Toilet	Amount of Leak/Accident	Activity During Leak	Drink Type/Amount
6:00 AM				
7:00 AM				
8:00 AM				
9:00 AM				
10:00 AM				
11:00 AM				
12:00 PM				
1:00 PM				
2:00 PM				
3:00 PM				
4:00 PM				
5:00 PM				
6:00 PM				
7:00 PM				
8:00 PM				
9:00 PM				
10:00 PM				
11:00 PM				
12:00 AM				
1:00 AM				
2:00 AM				
3:00 AM				
4:00 AM				
5:00 AM				
TOTAL				

NUMBER OF PADS USED: _____

Revised 10.24.19

PELVIC FLOOR CONSENT FOR EVALATION AND TREATMENT

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor symptoms include, but are not limited to, urinary for 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 are not 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. 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 this 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 or ____ refuse this option. (please check one)

Date: _____ Patient Name: _____

_____ _____

Patient Signature Signature of Parent or Guardian (if applicable)

_____

Witness Signature

REHAB PARTNERS, INC.

AUTHORIZATION FOR:
AUTHORIZATION FOR TREATMENT - ASSIGNMENT OF MEDICAL BENEFITS AND PAYMENT RESPONSIBILITY PT OT LMT

Patient's Name: _____
FACILITY / PROVIDER : REHAB PARTNERS, INC.

1.) **THE UNDERSIGNED**, hereby authorizes therapy at **REHAB PARTNERS, INC**. to render to patient Physical Therapy, Occupational Therapy, Massage Therapy or other related services (collectively, "Therapy Services") that provider or patient's treating physician determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Provider in connection with the Provider's rendition of therapy services.
2.) **THE UNDERSIGNED**, hereby certifies that all information provided to the Provider by the undersigned or patient including any information in connection for applying for payment under title XVIII of the Social Security Act is true, correct and accurate in all respects.
3.) **THE UNDERSIGNED**, hereby authorize Provider to disclose any information furnished to the Provider or obtained by Provider in connection with the patient's treatment (including information concerning a related Medicare claim) to any physician, governmental agency (including the Social Security Administrations or any of its intermediaries or carriers) insurance company or health care facility requesting such information.
4.) **THE UNDERSIGNED**, hereby assign to Provider all Medicare benefits to which the patient may be entitled for any therapy services rendered by the Provider. The undersigned hereby authorize and direct the Provider to apply and file for all such benefits on behalf of the patient in the event the patient is covered by both Medicare and Medicaid. The undersigned acknowledge that the Provider has disclosed to the undersigned that the Provider is a supplemental Medicaid Provider and the Provider is paid directly by Medicaid. In addition, the undersigned approves contact with the appropriate family members for medical or claims management purposes.
5.) **THE UNDERSIGNED**, hereby assign to the Provider all Private Medical Insurance benefits (primary and secondary, including med gap providers) or other benefits to which the patient may be entitled for any therapy services rendered by Provider. The undersigned hereby authorize and direct Provider to apply and file for all such benefits on behalf of the patient.
6.) **THE UNDERSIGNED**, agree that the undersigned shall be jointly and severally financially responsible for any portion of the Providers invoice that is not paid, except in the case of a Medicare denial or Medicaid eligible recipients. The undersigned warrant and represent to the Provider if member is a Medicare participant that patient is not a member of or covered by a Health Maintenance Organization or similar arrangement as their primary insurance coverage. The undersigned shall be liable to Provider for all services rendered by Provider in the event the patient is covered by a Health Maintenance Organization or similar arrangement.
7.) **THE UNDERSIGNED**, and patient if applicable agree to execute any documents and perform any acts that the Provider may reasonably request. The undersigned warrant and represent that attached hereto are originals or certified copies of any Powers of Attorney, Health Care Surrogate or Court Orders appointing the undersigned as the legal guardian of the patient.
8.) **THE UNDERSIGNED**, agree that the provisions hereof shall continue in full force and effect until Provider received written notice of termination by the undersigned: provided however that the provisions in paragraphs 1,2,3,4,5,6, and 7 shall survive any such termination.

WITNESSES:

_____

_____

_____

X _____
PATIENT SIGNATURE / LEGAL REPRESENTATIVE

DATE:_____

_____
FINANCIALLY RESPONSIBLE PARTY IF NOT PATIENT

DATE: _____

HIPAA NOTIFICATION

REHAB PARTNERS, INC. IS REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION AND TO PROVIDE YOU NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES AND ADHERE TO THIS NOTICE. WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY INDENTIFIABLE HEALTH INFORMATION THAT WE MAINTAIN. IF WE DO CHANGE OUT INFORMATION PRACTICES, WE WILL POST A NOTICE THAT THE NOTICE HAS CHANGED AND THE EFFECTIVE DATEOF THE CHANGE. COPIES WILL BE MADE AVAILABLE UPON REQUEST.

I UNDERSTAND THAT REHAB PARTNERS, INC. HAD MADE AVAILABLE TO ME A COPY OF THE NOTICE OF PRIVACTY PRACTICES. BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES.

PATIENT SIGNATURE: _____

DATE: _____

Because of the nature of this practice, it may be necessary to contact you by telephone for examination results, scheduling, appointments, billing, etc. HIPAA requires that we obtain specific consent from our patients allowing us to speak with others on your behalf should you not be available. Please indicate below the names, relationships, and date of birth of those you will allow us to speak with on your behalf. This would include your SPOUSE, FAMILY MEMBERS, CARE GIVERS, ETC.

NAME: _____

RELATIONSHIP: _____

DATE OF BIRTH: _____

NAME: _____

RELATIONSHIP: _____

DATE OF BIRTH: _____

NAME: _____

RELATIONSHIP: _____

DATE OF BIRTH: _____

If you **DO NOT** want us to speak with anyone with regards to your treatment, appointments, billing, etc. please indicate so by signing below.

NAME: _____

DATE: _____