FEMME PHYSIOCARE PATIENT INTAKE FORM

Personal Information

Full Name(First, Last): Middle Initial:

DOB (mm/dd/yyyy):

Home Address: Street: Apartment Number:

City: Province: Postal Code:

Email Address:

Primary Phone #: Alternate Phone #:

Health Card Number: Health Card Expiry (if applicable, mm/dd/yyyy):

Emergency Contact Person: Relationship: Primary Phone #:

Referral Family Doctor: Referring Physician:

Have you ever been treated previously on the same injury: ☐ Yes ☐ No. If yes, please elaborate:

How did you hear about our clinic?

☐ Website Yellow Pages ☐ Events Promotion ☐ Doctor Referral ☐ Social Media ☐ Search Engine ☐ Midwife/Chiro

☐ Family/Friend

Coverage Type

☐ No Coverage

☐ Extended Health Benefits (Complete section below)

☐ Motor Vehicle Accident (MVA/MVC) (Complete Additional Insurance Page, Section B)

☐ Workplace Injury (WCB/WSBC/WSNB/WSIB) (Complete Additional Insurance Page, Section C)

Extended Health Benefits Information/MVA Information

Name of Insurance Company:

Name of Policy Holder (Self):

Policy Holder DOB (mm/dd/yyyy):

Policy Holder's Relationship to Patient:

Policy / Claim No.:

ID / Certificate / Perm No.:

Name of Employer:

Secondary Extended Health Care Information (if applicable)

Name of Insurance Company:

Name of Policy Holder (Self):

Policy Holder DOB (mm/dd/yyyy):

Policy Holder's Relationship to Patient:

Policy / Claim No.:

ID / Certificate / Perm No.:

Name of Employer:

Billing Options (please check):

☐I agree to have the clinic direct bill my insurance plan. All information and forms have been given and signed. I fully understand the policy for direct billing.

☐I prefer to pay upfront and submit my treatment receipts on my own. I have read the above information and fully understand the billing policy.

Client Signature:

CONSENT FOR PELVIC FLOOR EVALUATION AND TREATMENT

Informed consent for treatment:

The term" informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

I also 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 therapists 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. I will have the opportunity to give/revoke my consent at each treatment session.

Treatment may include, but is 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.

Potential risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my therapist.
Potential benefits: may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.
Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.
Release of medical records: I authorize the release of my medical records to and from my physicians/primary care provider/midwives (if applicable) or insurance company.
Cooperation with treatment: I understand that 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.
Cancellation Policy: I understand that if I cancel more than 48 hours in advance, I will not be charged. I understand that if I cancel less than 48 hours in advance, I will pay a cancellation fee of $40.00
No warranty: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for improvement in my condition. I understand my therapist will share with me her opinions regarding potential results of physical therapy for my condition and will discuss all treatment options with me before I consent to treatment.

I have informed my therapist of any condition that would limit my ability to have an evaluation or be treated. I herby request and consent to the evaluation and treatment to be provided.

____
Patient Name

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Patient Signature Date

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