

Pelvic Health and Rehabilitation Center
PHRC, LP

Patient Registration Form

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-mail address: _____ Work Phone: _____

Date of Birth: _____ Social Security #: _____

Date of First Symptom: _____ Sex: Male / Female (circle one)

Referred by: _____

Person to Notify in Emergency: _____

Relationship: _____ Phone #: (_____) _____

Payment Authorization and Patient Responsibility

I hereby authorize the Pelvic Health and Rehabilitation Center to furnish my insurance company with any information that may be requested concerning payments of benefits. I understand that I am financially responsible for all charges, whether covered by my insurance or not. I further understand that it is my responsibility to obtain the necessary referrals and/or pre-authorizations from my insurance company.

Signature: _____ Date: _____

If patient is a minor, authorization to treat patient.

Signature: _____ Date: _____

PHRC PATIENT POLICIES
Effective July 17, 2006

Initial

New and Current Patients: Welcome to the Pelvic Health and Rehabilitation Center! We look forward to working with you. Please read the following information and feel free to ask any questions you may have.

Office Hours: Monday-Friday 8:00am-6:00pm by appointment only.

Insurance: We do not contract or participate with insurance plans other than Brown and Toland Medical Group HMO. Patients without Brown and Toland are responsible for payment of the entire visit at the time services are rendered. Brown and Toland patients are responsible for ensuring they are authorized for treatment at the time services are rendered, and for any co-payments they may have.

MediCare: We are not a contracted Medicare provider. As an unfortunate result, federal law prohibits us from treating MediCare Part B recipients, regardless of payment method. Therefore, by signing this document, you are confirming that you are not a current MediCare Part B recipient.

Insurance Billing: Patients will be provided with a copy of their bill at the end of each visit and they can submit the bill to their insurance company if they so choose. We will also assist patients in facilitating reimbursement if necessary.

Medical Record Copies: We charge for copies of medical records when requested from patients, insurance companies, and other doctor's offices. The patient is responsible for all copy charges. Copy charges are \$25.00 for small records and \$50.00 for large records.

Appointments: Appointments can be made either during phone hours or with your provider. At any given time, our books will be open for the current month and the following month. For example, as of August 1st our books will be open for August and September. As of September 1st, our books will be open for September and October. Patients are responsible for knowing their scheduled appointments as reminder calls will not be made.

Appointment Cancellations: The Pelvic Health and Rehabilitation Center has an extensive waiting list for appointments. As a result, we ask that patients provide at least **24 hours** notice if you cannot keep your appointment. If an appointment cannot be kept, or less than 24 hours notice is given, the patient is responsible for the entire cost of the visit.

A credit card is required to hold new patient appointments and current appointments. In the event of a missed appointment/insufficient time frame cancellation the credit card will be charged the cost of the visit. A signed consent form is required from all patients.

If a patient misses 3 appointments, the Pelvic Health and Rehabilitation Center reserves the right to cancel all future appointments.

Late Arrivals: Patient will be charged the fee for the entire scheduled appointment regardless of the time the patient arrives.

Privacy Notice: A copy of our Notice of Privacy Practice is available upon request.

Other Fees: There is a charge of \$50.00 for letters and/or reports that your provider writes on your behalf.

Print Name: _____

Signature: _____

Date: _____

Pelvic Health and Rehabilitation Center Consent for Evaluation and 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, dysfunction or pain with bowel, bladder or sexual function, 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 externally and/or internally. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar and nerve mobility and tenderness, as well as the function of the pelvic floor region.

Treatment may include, but not be limited to the following: observation, palpation, stretching and strengthening exercises, relaxation techniques, soft tissue and/or joint mobilization and educational instruction. Evaluation and treatment may result in emotional distress or discomfort, and that if I am unable to tolerate the evaluation or treatment I have the right to terminate the therapy session at any time.

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.
2. I understand that I can terminate the 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 procedure.
4. I have the option of having a second person present in the room during the procedure. If I elect to have a second person present in the room I understand I am responsible for providing a volunteer to be present during the examination and/or treatment.

Please circle one:

I choose this option

I decline this option

Patient Name (Please Print)

Patient Signature

Witness Name (Please Print)

Witness Signature

DATE: _____

HIPAA Notice of Privacy Practice

Pelvic Health and Rehabilitation Center - San Francisco, CA

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

- I. HIPAA defined:** The health insurance portability and accountability act of 1996 (HIPAA) is federal law which requires that medical records and individually identifiable health information be kept confidential, and that its uses and disclosures be in accordance with the law. The regulations which pertain to HIPAA (privacy rules) went into effect in 2003. The HIPAA standards, which require that patients be given a printed notice explaining the new privacy rules, are in addition to the long standing confidentiality provisions under California state law.

HIPAA applies to certain healthcare entities (“covered entities”) which submit billing information electronically. Covered entities must safeguard all protected health information (“PHI”) regardless of its form (i.e. paper, faxes, electronic files, etc). As mandated by HIPAA, this notice is an explanation of the privacy requirements concerning your health information, and how your PHI may be used and disclosed.

- II. LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)** By law your PHI is kept private. The PHI consists of information created or noted that can be used to identify you. It may contain data about your past, present, or future health or condition, the provision of healthcare services to you, or the payment for such healthcare. Use of PHI means to share, apply, utilize, examine, or analyze information. PHI is disclosed when there is a release transfer or other disclosure to a third party. With some exceptions, (“treatment”) one may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made.

III. HOW YOUR PHI IS USED AND DISCLOSED

PHI is disclosed for various reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find categories of uses and disclosures with some examples.

- A. Uses and disclosures related to treatment, payment, or healthcare operations do not require your prior written consent,** A provider may use and disclose your PHI without your consent for the following reasons:
- 1. For treatment-** which includes providing, coordinating, or managing healthcare and related services, your PHI may be disclosed to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with healthcare services or are otherwise involved in your care.
 - 2. For healthcare operations-** your PHI may be disclosed to facilitate the efficient operation of a healthcare practice. This may include quality assessment, improvement activities; auditing; peer review and training; and cost management analysis. Example: your PHI may be used in the evaluation of the quality of healthcare services that you have received or to evaluate the performance of the healthcare professional who provided you with these services. Note that we may also create and distribute de-identified health information by removing references to individually identifiable health information.

3. **To obtain payment for treatment-** your PHI may be used to bill and collect payment for the treatment and services provided to you. Example: sending your PHI to your insurance company or health plan in order to get payment for the healthcare services provided to you; this includes providing your PHI to billing agents, claims processing entities, and other business associates who process healthcare claims.
 4. **Other disclosure:** examples: your consent isn't required if you need emergency treatment.
- B. **Certain other uses and disclosures do not require your consent.** Other use and/or disclosure of your PHI without your consent or authorization is permitted as follows:
1. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.** Example: Disclosure to the appropriate official when a law requires a report of information to government agencies, law enforcement personnel, and/or an administrative proceeding.
 2. **If disclosure is compelled by a party to a proceeding before a court or administrative agency pursuant to its lawful authority.**
 3. **If disclosure is required by a search warrant lawfully issued to a law enforcement agency.**
 4. **If disclosure is compelled pursuant to California state laws or to corresponding federal statutes of regulations.**
 5. **To avoid harm.** PHI may be provided to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.
 6. **If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or others, and the disclosure is necessary to help prevent danger.**
 7. **If disclosure is mandated by the California State Child Abuse and Reporting law.**
 8. **If disclosure is mandated by the California State Elder/Dependent Adult Abuse Reporting Law.**
 9. **If disclosure is compelled or permitted because there is a serious/imminent threat of physical violence by you against a reasonable identifiable victim or victims.**
 10. **For public health activities.** Example: in the event of death, disclosure is permitted to give the county coroner information about you.
 11. **For health oversight activities.** Example: To assist the government in the course of an investigation or inspection of a healthcare organization or provider.
 12. **For specific government functions.** Examples; Disclosure of PHI of military personnel and veterans under certain circumstances. Also, disclosure of PHI in the interests of national security, such as protecting the president of the United States or assisting with intelligence operations.
 13. **For workers compensation purposes.** Disclosure of Phi in order to comply with workman's compensation laws.
 14. **If an arbitrator or arbitration panel compels disclosure,** when arbitration is lawfully requested by either part, pursuant to subpoena duces tectum (e.g. a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
 15. **You may be contacted without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits.**
 16. **If disclosure is otherwise specifically required by law.**

- C. **Certain uses and disclosures require that you have the opportunity to object.**
 - 1. **Disclosures to family, friends, or others.** As you direct, PHI may be provided to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment of your healthcare.
- D. **Other uses and disclosures require your prior written authorization.** In any other situation not described in sections IIIa, IIIb, and IIIc above, written authorization is required before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization in writing to stop additional disclosures, other than those releases made reliant on your prior authorization.

IV. **Rights you have regarding your PHI.** These are your rights with respect to your PHI, which you can exercise by sending a written request to the privacy officer listed at the end of this notice:

- A. **The right to see and get copies of your PHI.** In general, you have the right to see your PHI maintained by a healthcare provider, and to get copies of it.
- B. **The right to request limits on uses and disclosures of your PHI.** You have the right to ask for limits on how your PHI is used and disclosed. Your request will be considered but the provider is not legally bound to agree to additional limitations, beyond those required by law. If the additional limits you request are agreed to, they will be documented in writing. They will be adhered to, except in emergency situations. You do not have the right to limit the uses and disclosure that a provider is legally required or permitted to make.
- C. **The right to choose how your PHI is sent to you.** It is your right to ask that your PHI be sent to you at an alternate address (for example, sending info to your work address instead of your home) or by an alternate method (for example, by email instead of regular mail). Your request will be honored provided that the PHI can be sent in the format you requested, without undue inconvenience.
- D. **The right to get a list (“accounting”) of the disclosures made.** You are entitled to a list of certain types of disclosure of your PHI. The list will not include uses or disclosures for treatment, payment, or healthcare operations, those sent directly to you, or to your family as you have directed; or those made pursuant to an authorization signed by you. Disclosure records will be held for 6 years with your treatment records.

Our response will be made to your request for an accounting of disclosures within 60 days of receiving your request. The list provided in response will include disclosures included in the previous 6 years unless you enter a shorter period. The list will include the date of the disclosure, to who disclosure of PHI was disclosed. (Including their address, if known), a description of the information disclosed, and the reason for the disclosure. The list will be given to you at no cost unless you make more than one request in the same year, in which case you will be charged a reasonable sum for the set fee for each additional request.

- E. **The right to amend your PHI.** If you believe that there is some error in your PHI or that important information has been omitted it is your right to request a correction of the existing information. Your request and the reason for the request must be made in writing. You will receive a response in 60 days of receipt of your request. Your request may be denied in writing, if: the PHI (a) correct and not complete upon providers review, (b) forbidden to be disclosed, (c) not part of treatment records, or (d) or written by someone other than the provider. A denial must be in writing and must state the reasons for denial. It must also explain your right to file a written statement objecting to your denial. If you do not file a written objection, you still have the right to ask that your request and denial be attached to any further disclosures of your PHI. If your request is approved, your changes will be made to your PHI. Additionally you will be notified that the changes will be made.
- F. **The right to get this notice.** You have the right to receive a written copy of this notice.
- V. **How to complain about privacy practices.** If, in your opinion, there have been violations of your privacy rights, or if you object to a decision about access to your PHI you are entitled to file a complaint with the person listed in section VI below.
- VI. **Person to contact about this notice or to complain about privacy practices.** If you have any questions about this notice or any complaints about the privacy practices of this provider, please contact Elizabeth Rummer Pelvic Health and Rehabilitation Center
- VII. **Effective date of this notice.** This notice went into effect April 14, 2003.

Acknowledgement of Notice of Privacy Practices

I acknowledge receipt of this notice.

Patient Name: _____

Date: _____

Signature: _____

**PELVIC HEALTH AND REHABILITATION CENTER
INTAKE FORM (FEMALE)**

Name _____ Date _____

DOB _____

1. Please respond to the following statements regarding your PAIN symptoms:

- Nature (stabbing, burning, aching, etc.):

- Location (please list all areas of pain):

- Aggravating factors:

- Alleviating factors:

- Is the pain intermittent or constant:

- When symptoms began:

- What do you think caused the symptoms?

2. Please answer the following questions regarding your URINARY symptoms:

- Do you have difficulty initiating your stream (urinary hesitancy)?

- Is the stream weak and/or interrupted?

- How many times a day do you void?

- How many times do you wake up at night to void?

- Do you experience pain before, during, or after voiding?

- Do any behaviors aggravate your urinary symptoms?

- Does anything (positions, diet, etc,) improve your urinary symptoms?

3. Please answer the following questions regarding your BOWEL habits:

- Do you have a history of constipation?

- How often do you have a bowel movement?

- Do you experience pain before, during, or after a bowel movement?

- Do you have anal fissures or hemorrhoids?

- Does anything make your bowels better or worse?

4. Please answer the following questions regarding SEXUAL functioning:

- Is intercourse painful (initial penetration and/or deep discomfort)?

- Are you able to have an orgasm?

- Do you experience pain or urinary or bowel symptoms after intercourse?
If so, how long does it last?

5. How many physicians have you seen regarding this problem?

6. How long have you had your symptoms?

7. Please list all medications and amounts being taken.

8. Please list surgeries and medical interventions that you have undergone.