Cindi A. Prentiss, P.T., P.C.

Physical Therapy & Beyond

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PATIENT INFORMATION FORM

PLEASE PRINT LEGIBLY Today's Date____________________

First Name: ___________________ Last Name: ______________________ Social Security No: ______-____-______

Marital Status: (Circle One) Married/Single/Divorced/Widow/Widowed Spouse/Partner's Name: ___________________

Birth Date: ____________ Age: _______ Sex: M/F Height: ____/____ Weight: _____ R/L Hand Dominant: _______

Home Address: ____ Home Phone: (_____)____________

City / State / Zip: ____ Cell Phone: (_____)____________

Work Phone: (_____)____________ E-mail:______________________ Best way to contact you? _____________

Employer Name / Work Address: ____

Current Work Status: Full Time Part Time Retired Unemployed On Disability Restricted Work

Student Homemaker Not Working Due to Injury Occupation: ______________________________

Is this condition due to: ____Auto Accident ____Workers Comp Injury ____Slip & Fall ____Other

If you currently have an attorney working with you, please provide his/her name and address:

____

Have you received **physical therapy**, **occupational therapy**, and/or **speech therapy** since January 1st of this calendar year? Yes/No If yes, which therapy did you have and what were you being treated for?

____

Are you now having homecare services of any kind? Yes / No

Whom may we thank for referring you? ____

Please mark * ***C*** for ***Current*** Conditions or * ***P*** for ***Past*** Conditions

___Fibromyalgia	___Neck Pain	___Knee/Lower Leg Pain	___Heart Disease	___High Blood Pressure	___Hepatitis
___Rheumatoid Arthritis	___Back Pain	___Ankle/Foot Pain	___Angina	___Stroke	___Cancer
___Osteoarthritis	___Sciatica	___Jaw Pain	___Pacemaker	___Lupus	___Tumor
___Osteopenia	___Abnormal Posture	___Hearing Loss	___Diabetes	Difficulty ___Walking	___HIV/Aids
___Osteoporosis	___Headaches	___Kidney Disorder/Stones	___Neuropathies	___Parkinson's Disease	___Asthma
___Broken Bones	___Shoulder Pain	___Prostate Problems	___Peripheral Vascular Disease	___Multiple Sclerosis	___COPD
Joint ___Swelling/Stiffness	___Elbow/Upper Arm pain	___Painful Urination	___General Fatigue	___Muscular Dystrophies	___Cigarette Smoker
___Dermatitis/Eczema /Rash	___Wrist/hand pain	___Bladder Infection	___Lack of Coordination	___Epilepsy	___Drugs/Alcohol Dependence
___Hip/Upper leg Pain	___Loss of Bladder Control	___ Pelvic Pain	___Vertigo	___Liver/Gall Bladder Disorder	___Depression ___Other

Current Medications

Prescription	***Non-Prescription***

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Allergies:	

Rev. 11/11

Please state the body parts where your problems or injuries are located, and give a brief description of your current problems including difficulties with any functional activities: ____________________________________
____
____

Please give a ***date*** (actual or approximate) this problem started: ______________________________________

Please describe ***how*** your condition or injury started: ____
____

Have you ever been treated for this condition before? Yes / No

Date and location where you were last treated: ____

Are you currently being seen by a chiropractor for the same condition? Yes / No

Please check any of the following characteristics that you are feeling:

____Sharp Pain ____Dull Ache ____Throbbing ____Numbness ____Burning ____Pins/Needles

____Constant ____Usually present ____Sometimes present ____Occurs once in a while

Please circle the number that represents the intensity of your pain *when you are at rest*:

(No Pain) (Minimal Pain) (Moderate Pain) (Unbearable Pain)

0 1 2 3 4 5 6 7 8 9 10

Please circle the number that represents the intensity of your pain *during any movements*:

(No Pain) (Minimal Pain) (Moderate Pain) (Unbearable Pain)

0 1 2 3 4 5 6 7 8 9 10

Please check all the problems that you currently have:

_____Pain _____Shooting Pain _____Inability to work _____Difficulty walking

_____Weakness _____Loss of Motion _____Muscle tightness _____Loss of Balance

_____Stiffness _____Loss of Function _____Extreme Fatigue _____Unable to walk stairs

_____Headaches _____Unable to sleep

Please state anything that makes your problem ***better***: ____
____
____

Please state anything that makes your problem ***worse:*** ____
____
____

When is your next appointment with the doctor who is seeing you for this condition? ___________________

What are your ***goals*** you would like therapy to help you with? _________________________________
____
____
____

____ ____________________

Patient Signature Date

Cindi A. Prentiss PT, P.C.

Rev.11/11

Cindi A. Prentiss, P.T., P.C.

Male Consent Form

Thank you for choosing Cindi A. Prentiss, P.T., and P.C. for your physical therapy services. In order to provide a thorough physical therapy evaluation your physical therapist may perform an internal pelvic floor muscle examination, external pelvic musculature examination and may also examine the urogenital region. You and your physical therapists have discussed why this evaluation is needed and how it will be performed.

Your physical therapist is a female. No chaperone will be provided during your physical therapy evaluation and treatment sessions unless you request a chaperone be present. You may choose to bring a friend or family member during the physical therapy evaluation or treatment at any time.

By signing below, you consent to the examinations listed above and agree that your questions have been answered.

Patient's Name: ________________________ Patient's Signature: ______________________

Date: _________________________________ Witness: __________________________

Consent for Pelvic Floor Biofeedback

Thank you for choosing Cindi A. Prentiss, P.T., and P.C. for your physical therapy services. You and your physical therapist have decided that further modalities in the pelvic floor region may be necessary to promote healing and/or relieve pain. Please read the following and confirm that to your knowledge, you do not have any of these medical conditions.

1. Prostate surgery date: ________________________
2. Fusion, unfixated fracture, recently sutured nerves or tendons.
3. Cardiac pacemaker, history or cardiac arrhythmia.
4. Metal implants.
5. Recent rectal bleeding.
6. Malignancy in the area to be treated.
7. Known skin irritations due to the use of gel or tape.
8. Recent history of urinary retention or post void residual volume greater than 200cc
9. Diminished sensory perception.
10. Active urinary tract infection or infectious lesions.

Please check your response below:

☐ **I confirm to the best of my knowledge that I do not have any of the above listed medical conditions.**

☐ **I do have at least one of the above listed medical conditions, which I have circled, and I will further discuss with my therapist.**

I consent to the Pelvic Floor Biofeedback

Patient's Name: ______________________ Patient's Signature: ______________________

Date: _________________________ Witness: __________________________

Cindi A. Prentiss PT, P.C.

Cindi A. Prentiss P.T., P.C
MEN'S HEALTH SURVEY

Surgical History: (check all that apply & state year)

__ back/neck surgery
__ bladder repair
__ gall bladder surgery
__ hernias
___ kidney surgery
___abdominal surgery
___ appendectomy
Do you have scars from surgery? _______
Where are the scars? _______________________
Other ____

Daily fluid intake:
# of cups per day _____. What do you drink? ______________ Of those how many are caffeinated?_____
Do you restrict fluids because of your incontinence? Yes No

Previous Treatment for Incontinence

Have you done exercise to control urine loss?	*Yes*	*No*
Has your doctor prescribed any medication to treat urine loss?	*Yes*	*No*
Have you had any surgical procedures to treat urine loss?	*Yes*	*No*

Do you experience any of the following?

Loss of urine with coughing, laughing, sneezing?	*Yes*	*No*
Loss of urine when lifting objects?	*Yes*	*No*
Loss of urine with exercise, running, etc?	*Yes*	*No*
Loss of urine when you have strong urge to urinate?	*Yes*	*No*
Loss of urine on the way to the bathroom?	*Yes*	*No*
Loss of urine with "key in lock"? (can't make it to bathroom)	*Yes*	*No*
Loss of urine just as getting to toilet/remove clothes?	*Yes*	*No*

Do you:

Experience an urge to urinate when you hear running water and then you are unable to get to the toilet?	*Yes*	*No*
Have difficulty initiating a urine stream?	*Yes*	*No*
Have pain with urination?	*Yes*	*No*
Have burning with urination?	*Yes*	*No*
Have blood in urine?	*Yes*	*No*
Have to strain to empty your bladder?	*Yes*	*No*
Dribble urine when you urinate?	*Yes*	*No*
Dribble after you empty your bladder?	*Yes*	*No*

When you have an uncontrolled loss of urine:

Is it usually a little amount?	*N/A*	*Yes*	*No*
Is it usually a large amount?	*N/A*	*Yes*	*No*

Voiding Patterns:

Voiding frequency:	*# of times per day__________*	*# or times per night__________*
Incontinence:	*# of episodes per day_______*	*# of episodes per night________*
Amount of urine lost:	*______Large _____small*	*________few drops*

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Protective Devices:
What type of protective devices do you use? (Check all that apply)

(__Poise __Depends ___Serenity)	*Do you soak the pad fully? Yes No*
_____ incontinence brief	*Do you change the pad each time it is wet? Yes No*
_____ other_________________________________	

Bowel Habits:
How often do you have a bowel movement? ______________________________
Are you ever constipated *Yes No*
How do you resolve this?? ______________________________
Do you strain? *Yes No*
Do you experience diarrhea? *Yes No*
Do you use laxatives? *Yes No*
How often per week? ______________________________
Do you use enemas? *Yes No*
How often per week? ______________________________
Do you include fiber in your diet? *(fruit, vegetables, bran, etc.)* *Yes No*

Mobility/Self-Care
Do you:
Use a cane *Yes No*
Use a walker *Yes No*
Lean on furniture for balance? *Yes No*
Do you have difficulty?
with getting on/off the toilet? *Yes No*
getting clothes on/off? *Yes No*
with toilet hygiene? *Yes No*

Psychosocial Status:
Living arrangements:
Do you live alone? *Yes No*
*Occupation:*____
Do you do any recreational activities? Yes No What kind: ________________________
Have you had to restrict your activities due to urinary incontinence? Yes No
Have you had to restrict your activities due to pelvic pain? Yes No

What are your feelings about your urinary incontinence/pelvic pain on a scale of 1-10?
0 1 2 3 4 5 6 7 8 9 10
no impairment *severe impairment*

*Have you had changes in intimate relationships/sexual functioning due to **urinary incontinence**? Yes No*
*Have you had changes in intimate relationships/sexual functioning due to **pelvic pain**? Yes No*
*Have you had changes in intimate relationships/sexual functioning due to **ED**? Yes No* ______________________

Cindi A. Prentiss PT, P.C.

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PATIENT INSURANCE AND AUTHORIZATION FORM

Patient Name (print): _______________________________ Phone #: (_____)___________________________

Primary Insurance Carrier: ____________________________________ ID #: __________________________

Group #: __________________________________ Phone #: (_____)________________

Primary Insured: _________________________________ Date of Birth: ___/___/___ SS #: ______-_____-_____

Male/ Female Relationship to Patient: SELF SPOUSE CHILD OTHER

Adj /Caseworker:_________________________________ Adj. Phone #: _______________________________

Secondary Insurance Carrier: ____________________________________ ID #: __________________________

Group #: __________________________________ Phone #: (_____)________________

Named Insured: _________________________________ Date of Birth: ___/___/___ SS #: ______-_____-_____

Male/ Female Relationship to Patient: SELF SPOUSE CHILD OTHER

Tertiary Insurance Carrier: ____________________________________ ID #: __________________________

Group #: __________________________________ Phone #: (_____)________________

Named Insured: _________________________________ Date of Birth: ___/___/___ SS #: ______-_____-_____

Male/ Female Relationship to Patient: SELF SPOUSE CHILD

INSURANCE AUTHORIZATION SECTION

Physical Therapy & Beyond strongly believes that patients should not pay for any services their insurance companies are obligated to cover. As a courtesy to our patients, we will bill your insurance company in an attempt to recover any payments due fully for the services provided. Any uncollected fees are billed to the patient only after all options to get paid for services have been exhausted by our Accounting Department.

I understand that I am fully responsible for notifying Physical Therapy & Beyond of any changes regarding my medical coverage during ongoing treatment. The changes in medical coverage may include an auto accident, a work-related injury, termination of insurance, a change of insurance company and/or policies. ***If I do NOT comply with this policy, I understand and am fully aware I will be liable for any and all outstanding bills.***

I further understand that I am responsible for paying the balance of charges in the event my insurance does not fully cover for all services provided, including deductible, co-pay, co-insurance or percentage authorized or limited by law.

Additionally, I hereby authorize and assign insurance benefits to Physical Therapy & Beyond and the release of any and all medical records as requested by any insurance company so that my bills can be processed and paid.

____ ______________________________

Patient Signature (Parent Signature if under 18) Date

Acknowledgement of Notice of Privacy Practices

I, _________________________________, have been offered a copy of the Notice of Privacy Practices from Physical Therapy& Beyond. Patient Signature_________________________________ Date___________

In lieu of patient signature, I, __________________________, a staff member of Physical Therapy& Beyond, state that __________________________________ has been offered our current Notice of Privacy Practices.

Cindi A. Prentiss PT, P.C.

Cindi A. Prentiss P.T., P.C.

Patient Release Form

1. I authorize Cindi A. Prentiss, P.T., P.C., and /or staff to release information to the following physician (s):

Carbon Copy PT Reports to:

List the Physician writing your prescription so that we may send all your medical reports.

physicans name

address

city, state, zip

phone number

type of doctor

List other Physicians you would like us to send a copy of your physical therapy reports to.

physicians name	**physicians name**
address	address
city, state, zip	city, state, zip
phone number	phone number
type of doctor	type of doctor

Patient Signature **Date**

2. I authorize Cindi A.Prentiss, P.T., P.C., and /or staff to discuss my healthcare with the following person(s)

List the people in your personal life you are allowing us to share your info. with.

name	name
address	address
city, state, zip	city, state, zip
phone number	phone number
relationship to you	relationship to you

Patient Signature **Date**

3. I hereby authorize Cindi A.Prentiss, P.T., P.C. and/or staff to evaluate and treat my Son/ Daughter

______________________ for Physical Therapy.

Print Minor's Name

Parent or legal Guardian please sign here for minor Child.

Parent Signature **Date**

Witness Signature **Date**

Cindi A. Prentiss PT, P.C.

To Our Patient Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and or/your Physical Therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your Physical Therapist's instructions and we will be able to help you achieve your goals in treatment.

- We require 24 hour notice in the event of a cancellation. When you call in, it is your responsibility to have an alternative date and time in mind. This will ensure that you get the full prescribed number of treatments for that week whenever possible.

- There is a charge of $25 for a cancellation without proper notice. This charge will not be covered by insurance and must be paid by you personally.

- Worker's Compensation and Personal Injury patients are hereby informed that documentation of any missed appointments is forwarded to the Case Manager and Primary Physician and could jeopardize your claim.

- When rescheduling a missed appointment, you may need to see a therapist who you have not seen before. Be assured that all of our therapists are experienced professionals, who will study your patient chart, so you will be in good hands. You will return to your usual therapist in the next regularly scheduled visit.

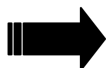
- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. The following may seem to be a reason not to come for your treatment. A) You're feeling worse and think the treatment is not working or B) You're feeling better and it's a great day for wind surfing. Neither of these conditions is legitimate as a reason not to come in. A) If you are in pain, come in and get it fixed, B) If you are out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem and educate you so you won't re-injure yourself.

To Our Patient Regarding Cancellations and No-Shows

When you don't show for a scheduled appointment, **three** people are hurt.

1. **You**, because you don't get the treatment you need as prescribed by the doctor and or the Physical Therapists.
2. **Your Physical Therapist**, who now has an open space in their schedule that was reserved for you personally.
3. **A Patient who is in pain** who could have been scheduled for treatment if you had given proper notice.

Please co-operate with us in this regard by signing the agreement below. We're looking forward to working with you.



________________________________ Date__________________

Patient Signature (Parent/ Guardian for Minor)

________________________________ Date__________________

Interviewer Signature