

# Duffy & Bracken

WELLNESS & FITNESS • PHYSICAL THERAPY, P.C.

## QUESTIONNAIRE FOR URINARY BOWEL CONTROL AND PELVIC FLOOR PAIN

(Check all that apply)

### Medical History

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Herpes
<input type="checkbox"/> Lung/breathing problems/asthma	<input type="checkbox"/> Stroke	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Food allergies	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> HPV
<input type="checkbox"/> Medication Allergies	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other virus
<input type="checkbox"/> Seasonal Allergies	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chronic Fatigue Syndrome
<input type="checkbox"/> Leg pain	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Pelvic pain
<input type="checkbox"/> Low back pain	<input type="checkbox"/> GI dysfunction	<input type="checkbox"/> Do you smoke?
<input type="checkbox"/> Are you pregnant?	<input type="checkbox"/> Depression	<input type="checkbox"/> Other medical history/injuries:
<input type="checkbox"/> Have you been in major accidents or falls?	<input type="checkbox"/> Are you being treated with medication therapy?	_____

### Gynecological History

Number of pregnancies		
Number of vaginal deliveries		
Dates of vaginal deliveries		
Length of pushing		
Did you tear?	Y	N
Number of episiotomies		
Do you have a painful episiotomy scar?	Y	N
Number of C-sections		
Do you have a history of urinary track infections?	Y	N
When was your Menopause onset?		
Do you have a history of urine loss as a child?	Y	N
Do you have a history of urine loss as an adult?	Y	N
Do you have a history of urine loss after child birth?	Y	N
Do you use a diaphragm?	Y	N
Do you use tampons?	Y	N

### Surgical History

<input type="checkbox"/> Back/neck surgery	<input type="checkbox"/> Gall bladder surgery	<input type="checkbox"/> Hysterectomy (abdom)
<input type="checkbox"/> Kidney surgery	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Hysterectomy (vaginal)
<input type="checkbox"/> Bladder repair	<input type="checkbox"/> Hernia	<input type="checkbox"/> Ovaries removed
<input type="checkbox"/> Other surgeries:		

### Current Pain

Do you have pain with:		
<input type="checkbox"/> Intercourse	<input type="checkbox"/> Ovulation (mid cycle)	<input type="checkbox"/> Contact with clothing
o Initial penetration	<input type="checkbox"/> Just before period	<input type="checkbox"/> Abdominal pain
o Deep penetration	<input type="checkbox"/> During period	<input type="checkbox"/> Sitting
o Erection	<input type="checkbox"/> After period	<input type="checkbox"/> Walking
o Ejaculation	<input type="checkbox"/> Full bladder	<input type="checkbox"/> Sleeping
o Orgasm	<input type="checkbox"/> While voiding	<input type="checkbox"/> Standing
o Arousal	<input type="checkbox"/> After voiding	<input type="checkbox"/> Other (explain)
<input type="checkbox"/> After intercourse	<input type="checkbox"/> Bowel movement	_____

Where is your pain currently? _____
What do you think is causing your pain? _____
Is there an event that you associate with onset of your pain? _____
If so, what? _____

**Current Medication** (prescription, non-prescription)

Have you been on Hormone Replacement Therapy?	Y	N
Dosage: <input type="checkbox"/> Estrogen <input type="checkbox"/> Progesterone	Type: <input type="checkbox"/> Pills <input type="checkbox"/> Patch/ring <input type="checkbox"/> Cream	

**Bladder**

Do you:		
Experience an urge to urinate when you hear running water or as you enter your home and are you then unable to get to the toilet?	Y	N
Have difficulty initiating a urine stream?	Y	N
Have difficulty stopping your stream?	Y	N
Have pain with urination?	Y	N
Have burning with urination?	Y	N
Have blood in your urine?	Y	N
Have to strain to empty your bladder?	Y	N
Dribble urine while you are urinating?	Y	N
Dribble after you empty your bladder?	Y	N
Have a "falling out" feeling?	Y	N

**Voiding Patterns**

Voiding Frequency:	# of times/day	# of times/night	
Incontinence:	# of episodes/day	# of episodes/night	
Amount of urine lost: (Check all that apply)	Large <input type="checkbox"/> Wet underwear <input type="checkbox"/>	Small <input type="checkbox"/> Wet outer clothes <input type="checkbox"/>	Few drops <input type="checkbox"/> Wet floor <input type="checkbox"/>

Urine loss caused by:	<i>Always</i>	<i>Sometimes</i>	<i>Never</i>
Laugh			
Cough			
Sneeze			
Walking			
Running			
Lifting			
Anxiety			
Urgency			
Intercourse			
Other: _____			

**Daily Fluid Intake**

How many cups of non-caffeinated/non-carbonated fluid are you drinking daily?
How many cups of coffee _____, caffeinated tea _____, soda _____, alcoholic beverages _____ are you drinking daily?
Do you restrict fluids because of your incontinence?

**Protective Devices**

What type of protective devices do you use? (check all that apply)		
<input type="checkbox"/> Panty liner		
<input type="checkbox"/> Sanitary pad (mini)		
<input type="checkbox"/> Sanitary pad (maxi)		
<input type="checkbox"/> Incontinence pad (poise <input type="checkbox"/> attends <input type="checkbox"/> serenity <input type="checkbox"/> )		
<input type="checkbox"/> Incontinence brief		
How many pads do you use each day?		
Do you soak the pad fully?		
	Y	N

**Previous Treatment for Incontinence**

Have you done exercises to control urine loss (Kegels)?	Y	N
Has your doctor prescribed any medication to treat urine loss?	Y	N
Have you had any surgical procedures to treat urine loss?	Y	N

**Bowel Habits**

How often do you have a bowel movement?		
Are you ever constipated?	Y	N
How do you resolve constipation?		
Do you use laxatives?	Y	N
How often do you use laxatives?		
Do you use enemas?	Y	N
How often do you use enemas?		
Do you include fiber in your diet (fruit, veg, bran, etc.)?	Y	N
Do you experience diarrhea?	Y	N
Do you experience loss of feces unexpectedly?	Y	N

**Mobility/Self-Care**

Do you use a cane/walker?	Y	N
Do get regular exercise – please explain?	Y	N
Do you lean on furniture for balance?	Y	N
Do you have difficulty with getting on/off the toilet?	Y	N
Do you have difficulty getting clothes on/off?	Y	N
Do you have difficulty with toilet hygiene?	Y	N

**Psychosocial Aspects**

Do you live alone?	Y	N
What is your occupation?		
Do you do any recreational activities?	Y	N
What kind?		
Have you had to restrict your activities due to urinary incontinence?	Y	N
Do you empty your bladder frequently so that you stay dry?	Y	N
Have you had changes in intimate relationships/sexual functioning due to your symptoms?	Y	N

What are your feelings about your urinary incontinence on a scale of 1 to 10:

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

No impairment

Severe Impairment

What are your feelings about your pain on a scale of 1 to 10:

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

No pain

Worst Pain Imaginable

Are you sexually active now	Y	N
Do you have anal intercourse	Y	N
Have you experienced sexual or physical abuse in the past	Y	N
What are your rehabilitation goals/expectations?		

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Duffy & Bracken

WELLNESS & FITNESS • PHYSICAL THERAPY, P.C.

DATE: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Phone: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

JOB TITLE/OCCUPATION: \_\_\_\_\_

BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_

SOCIAL SECURITY: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ SEX: \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

To All Our Patients,

As you know, we are committed to providing you the very best physical therapy care. Unfortunately, Medicare and health insurance companies do not cover supplies that will be provided during your care. Due to increase in costs without increased reimbursements we can no longer absorb these fees. We will therefore be charging you for the costs of the supplies which are separate from any co-payment you may have. **Thank you for trusting us with your PT needs. It is truly our honor and privilege to serve you.**

Here is the list of supplies and costs:

- |                 |             |
|-----------------|-------------|
| 1. Probes       | \$60        |
| 2. Taping       | \$5/session |
| 3. Kinesio tape | \$5/session |
| 4. Electrodes   | \$10        |
| 5. Heel raises  | \$10 each   |

SIGNED: \_\_\_\_\_

75 MAIDEN LANE, SUITE 404 – NEW YORK, NY 10038 – PHONE 212-402-5430 – FAX 212- 402-5432

**Patient Acknowledgement of Understanding of the  
Direct Access to Physical Therapy Regulations**

As of November 23, 2006, people in New York who need physical therapy services can go directly to their physical therapist without having to wait for a prescription from a physician. This DIRECT ACCESS TO PHYSICAL THERAPY LEGISLATION allows physical therapists to treat a patient for 10 visits or for a period of 30 days (whatever comes first) before a prescription from a physician must be obtained to continue physical therapy. Exceptions are no-fault and workers compensation, which still require a prescription at the first visit.

This is to acknowledge that I understand the New York State Direct Access to Physical Therapy Law and will obtain a prescription from my physician (either a specialist or primary care physician) after 10 visits or within 30 days of the start of my treatment at Duffy & Bracken Physical Therapy P.C.

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*Printed Name of Patient*

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*Signature of Patient*

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*Date*

# Duffy & Bracken

WELLNESS & FITNESS • PHYSICAL THERAPY, P.C.

75 MAIDEN LANE - NEW YORK, NY 10038 - PHONE (212) 402-5430 – FAX (212) 402-5432  
WWW.DUFFYANDBRACKEN.COM

## **NO-SHOW AND LATE CANCELLATION POLICY**

Please read and sign the following policy.

Because physical therapy requires frequent patient visits and new patients referred for treatment need to be scheduled and treated as promptly as possible, a tight scheduling procedure is required by this office in order to provide the best care to all our patients. When one does not show up for treatment, or cancels the same day, it is time taken away from others who could utilize that treatment time.

Duffy & Bracken charges a \$75.00 no-show/late cancellation fee. We define a NO-SHOW as a patient who does not appear for a scheduled appointment, or is more than 15 minutes late for their appointment time. We define a LATE-CANCELLATION as a patient who does not give us 24-hour notice of cancellation. **IMPORTANT NOTE:** Monday appointment cancellations must be called in **by 3:30 p.m. on the Friday before your appointment. The fee is your responsibility and will not be paid by your insurance company. It must be paid in full before your next treatment can be given.**

We advise you to consider the importance of attending your scheduled treatment. Please help us to give you and all of our patients the best treatment possible.

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### **PAYMENT RELEASE AUTHORIZATION**

I request that payment of authorized health benefits be made either to me or on my behalf to Duffy & Bracken Physical Therapy PC for any services furnished to me by the physical therapist. I authorize any holder of medical information about me to release to a representative of Duffy & Bracken any information needed to determine these benefits or the benefits payable for related services.

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### **PATIENT ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE**

I acknowledge that I have received and reviewed Duffy & Bracken Physical Therapy PC Notice of Privacy Practices. If I have any questions, I can call the Practice at (212) 402-5430

I HAVE READ AND UNDERSTAND THE TERMS OF THE ABOVE POLICIES:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

# Duffy & Bracken

PHYSICAL THERAPY, P.C.

## FINANCIAL POLICY STATEMENT

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy or your responsibility.

If you provide our office with the necessary information regarding your insurance plan, we will submit our claim directly to your carrier. **You are responsible to pay the appropriate deductible, co-pays and/or coinsurance, also any denial of payments from your insurance.** We accept all major credit cards; however cash or check is preferred for services rendered. **It is the policy of this office to keep a credit card on file. Please provide credit card information below for any unpaid accrued charges.**

### REGARDING INSURANCE

Physical therapy treatment can be provided without a prescription for the first 30 days or 10 treatments, whichever comes first but in some cases it may not be covered by your health care insurer without the referral of a physician or nurse practitioner, but may be a covered expense, if treatment was rendered pursuant to such referral.

If your plan requires authorization from your physician (primary or specialist), it is your responsibility to obtain the written referral or authorization prior to your visit at Duffy & Bracken. If you arrive at our office without proper authorization, full payment will be expected at time of service and refunded to you when authorization is obtained.

In addition, to comply with state regulations, you have to provide a prescription from your physician (primary care or specialist) within 30 days of the start of your treatment at Duffy & Bracken. Any denial of payment of services resulting from non-compliance with this policy will be billed to you.

Insurance is a contract between you and your insurance company. In most cases, we are NOT party to this contract. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, coinsurance, co-payments, referrals, "usual & customary charges," etc., other than to supply factual information as necessary. If you have not paid Duffy & Bracken and your insurance company inadvertently pays you directly, you must send this payment immediately to Duffy & Bracken. **Please note we will collect payment via credit card following five business days of notification of your check sent directly to you.**

The above does not apply for those patients that are considered Worker's Compensation. However be advised if your claim for Workers Compensation benefits is denied you may be held responsible for the total amount of charges for services rendered to you.

### **Duffy & Bracken preferred Method of Payment for deductibles and co-payments are:**

Cash: \$ \_\_\_\_\_ Check: \_\_\_\_\_ Money Order: \_\_\_\_\_

Co-pays, co-insurance, deductibles and fee for service must be paid at time of treatment. A \$10 service charge will be added if not paid on the day of your appointment.

**It is the policy of this office to keep a credit card on file. Please provide credit card information below for any unpaid accrued charges and/or fees.**

**Credit/Debit Card:** \_\_\_\_\_ **Card #:** \_\_\_\_\_

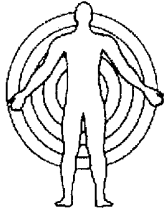
**Expiration date:** \_\_\_\_\_

**RESPONSIBLE PARTY SIGNATURE**

**DATE**

\_\_\_\_\_

\_\_\_\_\_



**Duffy & Bracken**  
PHYSICAL THERAPY, P.C.

Ann M. Duffy M.A., P.T.

### Patient/Client/Student Provider Email Agreement

As e-mail offers an easy and convenient way for us to communicate with each other, it is best to understand its uses and limitations:

- Commercial email providers (yahoo, hotmail, g-mail, etc.) are not considered secure means of communication for protected health information under HIPAA.
- If sending e-mails from your work address your employer has a legal right to read your e-mail if he or she chooses.
- E-mail may become a part of your chart.
- E-mails may be forwarded to my staff for handling, if appropriate.
- Either one of us can revoke permission to use the e-mail system at any time.
- Duffy & Bracken, Physical Therapy may email me bills/invoices.

I DO want to communicate with Ann Duffy, MA, PT or staff of Duffy & Bracken Physical Therapy electronically.

I have read the above information and understand the limitations of security on information transmitted.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Date: \_\_\_\_\_