corepelvic
PHYSICAL THERAPY

Conditions and Consent for Treatment

As a patient you have the right to be informed about your health condition(s) and about recommended rehabilitation treatments.

I, _____, request consent to examination and treatment for Physical Therapy.

- **I have the option of having a second person (spouse/relative/etc.) present in the room during the procedure. It is my responsibility to provide them.**

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. I understand that to evaluate my condition it may be necessary to have my therapist perform in 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. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

Potential risks

I may experience and increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my therapist at Core Pelvic Physical Therapy.

Cancellation Policy

If you need to change or cancel your appointment, please give us at least 24 hours notice. Initial Evaluations appointments that are either missed or cancelled with less than 24 hours notice will be charged a $100 fee. Daily appointments that are either missed or cancelled with less than 24 hours notice will be charged a $75 fee.

Payment

I have reviewed the clinic fees below and understand that I am responsible for payment at the time of service, unless previously arranged by Core Pelvic Physical Therapy. I understand that it is my responsibility to call my insurance company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of my benefits. At Core Pelvic Physical Therapy, we submit claims to the insurance provided on your behalf. Any denials or remaining patient responsibility will be invoiced to you (the patient) and is due at time of receipt.

I understand if I have an unpaid balance to Core Pelvic Physical Therapy and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of the fee of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable collection and attorney's fees incurred during collection efforts.

In order for Core Pelvic Physical Therapy or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Core Pelvic Physical Therapy and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

I have read the above information and I consent to physical therapy evaluation and treatment.

Printed name of patient/guardian:_____

Signature of patient/guardian:_____

Date signed:_____

PATIENT HISTORY FORM

PATIENT NAME _____ DATE _____

Reasons for Seeking Treatment:

1. Describe the current problem that brought you here:
2. When did this problem first begin? Please give approximate date:
3. Was your first episode related to a specific incident?
4. If pain is present, please rate your pain on a scale of 0-10 (10 being the worst):
5. Please describe the nature of your pain (constant, intermittent, burning, stabbing, shooting):
6. Since that time, is the problem: ☐ Staying the same ☐ Getting better ☐ Getting worse.
   Please describe why or how:

Occupation:

7. What is your current occupation?
8. Circle all that apply: Full time/Part time/ Volunteer/Retired
9. How has this problem limited daily/social/physical/work activities?
10. Amount and type of exercise per week:
11. On disability or leave? Y/N

How did you hear about us? Please circle best answer:

Insurance/Google/Dr. Referral/Personal Referral/Social Media/Other_____

Symptoms:

12. Activities that cause or aggravate your symptoms.
Please check/circle all that apply:

☐ Sitting greater than_ minutes	☐ With cough/sneeze/straining
☐ Walking greater than_ minutes	☐ With laughing/yelling
☐ Standing greater than_ minutes	☐ With lifting/bending
☐ Changing positions (i.e. sit-to-stand)	☐ With cold weather
☐ Light activity (light housework)	☐ With triggers (i.e. key in door)
☐ Vigorous activity/exercise (run/weight lift/jump)	☐ With nervousness/anxiety
☐ Sexual activity	☐ No activity affects the problem
☐ Other, please list:	

13. What, if anything, relieves your symptoms?

14. Do you have a previous history of similar symptoms?

15. Describe any previous treatment/exercises:

16. Did you have success with previous treatment? ☐ YES ☐ NO

17. How many pregnancies have you had?

18. How many live births?

19. Vaginal or C Section births?

Have you ever had any of the following conditions or diagnoses?

☐ Cancer	☐ Stroke	☐ Joint replacement
☐ Heart problems	☐ Epilepsy/seizures	☐ TMJ/neck pain
☐ High blood pressure	☐ Multiple sclerosis	☐ Emphysema/Asthma
☐ Ankle swelling	☐ Head injury	☐ Sexually transmitted disease
☐ Anemia	☐ Osteoporosis	☐ Physical or Sexual abuse
☐ Low back pain	☐ Chronic Fatigue Syndrome	☐ Pelvic Pain
☐ Sacroiliac/Tailbone pain	☐ Fibromyalgia	☐ Diabetes
☐ Childhood bladder problems	☐ Acid reflux or belching	☐ Kidney disease
☐ Depression	☐ Hypo/Hyper-thyroid	☐ Irritable Bowel Syndrome
☐ Allergies:	☐ Headaches	

PELVIC SYMPTOM QUESTIONNAIRE

PATIENT NAME _____ DATE _____

☐ MALE ☐ FEMALE

Bladder

1. Average fluid intake (one 8oz glass = one cup) _____. Of this total, how many glasses are caffeinated? _____. List types: _____
2. Frequency of urination:
   Awake hours: _____ times per day Sleep hours: _____ times per night
3. When you have a normal urge to urinate, how long can you delay before you must go to the toilet? ☐ minutes ☐ hours ☐ not able to delay
4. The usual amount of urine passed is: ☐ small ☐ medium ☐ large
5. Rate your feeling of "falling out" or prolapse or pelvic heaviness/pressure:

_____ None present
_____ With standing:
☐ for minutes ☐ for hours
_____ Times per month:
☐ related to activity _____
☐ related to menstrual period
_____ With exertion or straining
Other: _____

6. What form of protection do you wear? (Please select only one)

_____ None
_____ Minimal protection:
☐ tissue paper ☐ panty-liner
_____ Moderate protection:
☐ absorbent product ☐ maxi-pad
_____ Maximum protection:
☐ diaper ☐ specialty product
☐ other: _____

On average, how many times do you have to change your protection in 24 hours? _____

7. Describe your urinary process by checking all that apply below:

- ☐ Trouble initiating urine stream
- ☐ Difficulty stopping urine stream
- ☐ Dribbling after urination
- ☐ Recurrent bladder infections
- ☐ Strain or push to empty bladder
- ☐ Blood In urine
- ☐ Other, describe: _____
- ☐ Urinary Intermittent/slow stream
- ☐ Trouble emptying bladder completely
- ☐ Constant urine leakage
- ☐ Painful urination/ burning
- ☐ Have "falling out" feeling
- ☐ Trouble feeling bladder urge

8. On average, how much urine do you leak?

_____ No leakage
_____ Just a few drops
_____ Wets underwear
_____ Wets outer clothing
_____ Wets the floor

Bowel

1. Frequency of bowel movements:
   _____ Times per day

2. The bowel movements are: ☐ watery ☐ loose ☐ formed ☐ pellets ☐ other: _____

3. If constipation is present, describe management techniques: _____

4. When you have an urge to have a bowel movement, how long can you delay before going to the toilet? ☐ Minutes ☐ Hours ☐ Not able to delay

5. Describe your elimination process by checking all that apply below:

☐ Blood in stool/feces	☐ Trouble emptying bowel completely
☐ Seepage/loss of BM without awareness	☐ Constipation/straining
☐ Painful bowel movements (BM)	☐ Trouble feeling bowel urges/fullness
☐ Trouble controlling bowel urges	☐ Trouble holding bade, gas or feces
☐ Need to touch to complete BM	☐ Staining of underwear

☐ Current laxative use. Type: _____
☐ Other conditions, describe: _____
_____

6. On average, how much stool do you lose?

_____ ☐ No leakage
_____ ☐ Stool staining
_____ ☐ Small amount in underwear
_____ ☐ Complete emptying
_____ ☐ Other: _____

Pelvic Distress Inventory- Short Form 20

Name:_____ Todays Date: _____

Please answer all the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms. If you do, how much do they bother you. Answer each question by putting a check mark in the appropriate box. If you are unsure about how to answer, please give the best answer you can.

	NO	YES			
	Not Present	Not at All	Somewhat	Moderately	Quite a Bit
1. Do you usually experience pressure in the lower abdomen?					
2. Do you usually experience heaviness or dullness in the lower abdomen?					
3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?					
4. Do you usually have to push on the vagina or around the rectum to have a complete bowel movement?					
5. Do you usually experience a feeling of incomplete bladder emptying?					
6. Do you ever have to push up in the vaginal area with your fingers to start or complete urination?					
7. Do you feel you need to strain too hard to have a bowel movement?					
8. Do you feel you have not completely emptied your bowels at the end of a bowel movement?					
9. Do you usually lose stool beyond your control if your stool is well formed?					
10. Do you usually lose stool beyond your control if your stool is loose or liquid?					
11. Do you usually lose gas from the rectum beyond your control?					
12. Do you usually have pain when you pass your stool?					
13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?					
14. Does part of your bowel ever pass through the rectum rectum and bulge outside during or after a bowel movement?					
15. Do you usually experience frequent urination?					
16. Do you usually experience leakage associated with a feeling of urgency?					
17. Do you usually experience urine leakage related to laughing, coughing, or sneezing?					
18. Do you usually experience small amounts of urine leakage? (i.e drops)					
19. Do you usually experience difficulty emptying your bladder?					
20. Do you usually experience pain or discomfort in your lower abdomen or genital region?					

Disclaimer and Liability Release

BEMER HUMAN SETS

BEMER is intended for use in the prevention and further therapy of diseases that are caused, accompanied or complicated by microcirculatory issues due to reduced vasomotility. Any other use is considered “not indicated on the label” and therefore prohibited.

BEMER does not provide any medical advice or service. Nothing provided by BEMER in connection with the BEMER shall be construed to provide professional medical advice, diagnosis or treatment and you must not rely on or take it to the letter. Before starting a health, protocol or starting to use a medical device such as BEMER or if you have any medical concerns, pre-existing injuries or illness, please consult a licensed health care provider.

BEMER should not be used for organ transplantation, immunosuppressive therapy or pregnancy without first consulting a physician. You agree that you understand these limitations, have had the opportunity to obtain more information about them and consult your doctor if you have any questions or concerns.

For more information, please consult the product manual or call BEMER at 1-800-554-9117.

You hereby release and hold BEMER, its parent, subsidiaries and affiliates and their officers, directors, employees, agents, attorneys, affiliates, partners, contractors, assigns and permitted assigns (“us”) harmless from any and all loss, liability damages, costs, claims, demands or causes of action of any nature and kind, known or unknow, which you or any third party has or may in the future have against us resulting directly or indirectly from your use of the BEMER products. You agree that any claim you may have against BEMER or a BEMER distributor related to your use of a BEMER product must be filed within one year after such claim arose; otherwise your claim is permanently barred.

By signing below, you acknowledge that you have the legal right to perform this disclaimer and have read, understood and accepted all of the foregoing.

1) Do you take the medication Xarelto? YES NO
2) Have you received a solid organ transplant AND are on immunosuppression medication?

   YES NO
3) Are you pregnant? YES NO
4) Do you have a history of Deep Vein Thrombosis of Pulmonary Embolism? YES NO

Signature:_____ Date:_____

BTL EMSELLA

Print Name:_____

Treatment Considerations

You are scheduled for a series of non-invasive treatments with the BTL EMSELLA device.

BTL EMSELLA is intended to provide entirely non-invasive electromagnetic stimulation of the pelvic floor musculature for the purpose of rehabilitation of weak pelvic muscles and restoration of neuromuscular control for the treatment of urinary incontinence and sexual dysfunction.

Your provider will discuss your specific treatment needs. The recommended number of treatments is 6. Recommended treatments are 2 sessions per week for 3 weeks. Each session is 28 minutes. Completing a full treatment series is necessary to maximize treatment efficacy. You may need additional treatments depending on the severity of your condition. The results will typically continue to improve over the next few weeks.

There is typically no pain associated with your treatment and there is no anesthetic required. You will experience gradually increasing tingling and muscle contractions. These sensations in the pelvic area are normal and expected. You remain fully clothed during the treatment.

-I am aware that pregnancy is contraindicated and pregnant women can't undergo the treatment.

-I understand there are certain risks associated with BTL EMSELLA treatments and they include but are not limited to muscular pain, temporary muscle spasms, temporary joint or tendon pain, redness of the skin. I understand that the treatment may involve risks of complications or injury from both known and unknown causes, and I freely assume these risks.

-I am willing to fill in outcome measures for the purpose of medical evaluation of the results of the treatment. Information will be acquired for medical records or marketing purposes.

-I understand the results may vary from person to person and that an exact result cannot be predicted. It is very unlikely but it is possible that you will not feel any recognizable results after the procedure. I acknowledge the results may not meet my expectations.

-I certify that I have read this entire document and that I agree with all provisions. I certify that I have had the opportunity to ask questions and these questions have been answered in full to my satisfaction. I fully understand the treatment conditions, the procedure and possible side effects.

Please circle if you have or have had any of the following:

-Implanted defibrillators, implanted neurostimulators, pacemaker

electronic implants, metal implants, drug pump Yes No

-Pulmonary insufficiency, hemorrhagic conditions, anticoagulation therapy, heart disorders Yes No

-Malignant tumor Yes No

-Allergy to any medications, foods or substances, any skin disease or sensitivity Yes No

If you answered YES to any of these questions, please specify:_____

_____

_____

My signature below indicates that the above information is accurate and current.

Patient signature:_____ **Date**:_____

Practice Name: Core Pelvic Physical Therapy