The Overlook at Lake Julian
600 Julian Lane, Suite 660, Arden, NC 28704

1201 Bleachery Blvd, Suite 201
Asheville, NC 28803

Newbridge Commons
218 Elkwood Ave, Suite 103, Asheville, NC 28804

cornerstoneptnc.com P 828-684-3611 F 828-684-3612 cpt@cornerstoneptnc.com

PATIENT REGISTRATION

Date_______________ Patient Name______________________________ Birthdate_______________

Social Security Number __________________________Marital Status______________ Sex_________

If Under 18: Guardian's Name_______________________ Birthdate_________

Address______________________________________ City ______________ State ___ Zip ________

Phone Number ______________________________Cell_____________________________________

Email_____________________________________ Preferred Language_________________________

Race (optional)______________________________ Ethnicity (optional)___Hispanic ___Non-Hispanic

Employer____Occupation_________________________

Employer's Address____________________________________ Work Phone____________________

Notify In Emergency____________________Phone___________________Relation_______________

How did you hear about us?

Doctor: ____________________________

Dentist:_______________________________

Self-Referral: (circle one) Workshop Social Media Google Company Website Race/Event

Other: ____

Friend/Family: _____________________________

Is this due to an automobile accident or a work-related injury? ____Yes ____No If yes, please provide a contact name (Adjuster, Case Manger), phone number, claim number, etc. in order for us to properly bill your claims:____

____

The information above is given to the best of my knowledge and represents my current information. Failure to supply correct information may result in the patient being responsible for services rendered.

________________________________ **Patient/Guardian Signature**

________________________________ **Witness Signature**

________________________________ **Print Name**

________________________________ **Print Name**

CANCELLATION POLICY

If you need to change or cancel your appointment for any reason, we **request at least 48 hours' notice. Failure to call by 12 pm on the day prior to your appointment may result in a $50.00 fee not covered by insurance**. This fee will be due in full at your next treatment session. This advanced notice allows us to fill your slot with another patient in need of treatment. Repeated changes with or without notice, multiple cancellations, will result in restricting your ability to schedule future appointments.

I understand and agree to the terms stated above.

______________________________ ______________________________

Patient/Guardian Signature **Witness Signature**

______________________________ ______________________________

Print Name **Print Name**

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize Cornerstone Physical Therapy, Inc. to release all my (or my dependent's) records to: ***(Medicare & Medicaid patients must provide a primary care physician):***

City/State/Phone Number

Your family physician:

____

Other physician/provider:

____

Other physician/provider:

____

Family Members/Friends:

____

CONSENT TO TREAT:

______ I authorize Cornerstone Physical Therapy, Inc. to administer all necessary treatments and care
(initial) required for my (or my dependent's) rehabilitation.

HIPAA DISCLOSURE STATEMENT:

______ I acknowledge that I have been informed of the Provider Notice of Practices which is located in
(initial) the reception area of this facility.

PHONE CALL AUTHORIZATION:

I authorize Cornerstone Physical Therapy, Inc. to leave messages on my answering machine regarding relevant information. _____(Initial) _____(Decline)

I authorize Cornerstone Physical Therapy, Inc. to text message my cell phone for appointment reminders. I further understand that ***I cannot text message Cornerstone Physical Therapy, Inc. to cancel or reschedule my appointments, and that I must call the office to handle these matters.***

_____(Initial) _____(Decline)

I understand and agree to the all of the terms stated above.

______________________________ ______________________________

Patient/Guardian Signature **Witness Signature**

______________________________ ______________________________

Print Name **Print Name**

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Pelvic Floor Therapy Questionnaire (Male)

Name____ Date of Birth______________________
Preferred Pronoun: ______________________________ Sex/Gender _________________
Referring MD_______________________________________Occupation_____________________
Reason for Referral____

History

Please check that all apply:

☐ High blood pressure
☐ Heart Disease
☐ Circulation Disease
☐ Thyroid Condition
☐ Diabetes

☐ Osteoporosis
☐ Arthritis
☐ Breathing problems
☐ Cancer
☐ Allergies

Height______

Weight______

Medications? ____
Surgeries?____
Any history of trauma?____
Other (Please list any other medical problems):____

Bladder Symptoms

Do you lose urine when you:

Yes	No	
☐	☐	Cough/laugh/sneeze?
☐	☐	On the way to the bathroom?
☐	☐	Hear running water?
		Other___________________
☐	☐	Do you wet the bed?
☐	☐	Have burning/pain with urination?
☐	☐	Difficulty starting a stream of urine?
☐	☐	Strain to empty your bladder?

Yes	No	
☐	☐	Lift/exercise/dance/jump?
☐	☐	Have strong urge to urinate?
☐	☐	Sexual activities?
☐	☐	Feel unable to empty your bladder?
☐	☐	Have a falling out feeling?
☐	☐	Have and urgency of urination?
☐	☐	Urinate more than 7 times a day?

Bowel Symptoms

Yes	No	
☐	☐	Strain to have a bowel movement?
☐	☐	Include fiber in your diet?
☐	☐	Take laxative/enema regularly?
☐	☐	Have very strong urge to move your bowels?

Yes	No	
☐	☐	Leak/stain feces
☐	☐	Have diarrhea often?
☐	☐	Leak gas by accident?

How often do you move your bowels: _______per day/per week

Most common stool consistency? ____liquid _____soft _____firm _____pellets _____other___________

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Pelvic Floor Consent for Evaluation and Treatment

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunction includes, 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 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. This evaluation will assess skin conditions, 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.

Treatment may include, but 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.
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 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 and discomfort or unusual symptoms during evaluation.
4. I have the option of having a second person present in the room during the procedure, that I will provide, and I _____choose_____decline this option.
5. I decline the option of internal exams_____

______________________________	______________________________
Patient Signature	Witness Signature
______________________________	______________________________
Print Name	Print Name