



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 _____ SSN _____
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? (List all that apply)

Doctor: _____ Social Media
Google Company Website

Dentist: _____ Friend/Family: _____

Event (Race / Wellness / etc.) / Other: _____

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 _____
Referring MD _____ Occupation _____
Reason for Referral _____

History

Please check that all apply:

- | | | |
|--|---|--------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Osteoporosis | Height _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Circulation Disease | <input type="checkbox"/> Breathing problems | Weight _____ |
| <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | |

Medications? _____

Surgeries? _____

Any history of trauma? _____

Other (Please list any other medical problems): _____

Bladder Symptoms

Do you lose urine when you:

- | | | | |
|--------------------------|---|--------------------------|---|
| Yes | No | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> Cough/laugh/sneeze? | <input type="checkbox"/> | <input type="checkbox"/> Lift/exercise/dance/jump? |
| <input type="checkbox"/> | <input type="checkbox"/> On the way to the bathroom? | <input type="checkbox"/> | <input type="checkbox"/> Have strong urge to urinate? |
| <input type="checkbox"/> | <input type="checkbox"/> Hear running water? | <input type="checkbox"/> | <input type="checkbox"/> Sexual activities? |
| | Other _____ | | |
| <input type="checkbox"/> | <input type="checkbox"/> Do you wet the bed? | <input type="checkbox"/> | <input type="checkbox"/> Feel unable to empty your bladder? |
| <input type="checkbox"/> | <input type="checkbox"/> Have burning/pain with urination? | <input type="checkbox"/> | <input type="checkbox"/> Have a falling out feeling? |
| <input type="checkbox"/> | <input type="checkbox"/> Difficulty starting a stream of urine? | <input type="checkbox"/> | <input type="checkbox"/> Have an urgency of urination? |
| <input type="checkbox"/> | <input type="checkbox"/> Strain to empty your bladder? | <input type="checkbox"/> | <input type="checkbox"/> Urinate more than 7 times a day? |

Bowel Symptoms

- | | | | |
|--------------------------|---|--------------------------|--|
| Yes | No | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> Strain to have a bowel movement? | <input type="checkbox"/> | <input type="checkbox"/> Leak/stain feces |
| <input type="checkbox"/> | <input type="checkbox"/> Include fiber in your diet? | <input type="checkbox"/> | <input type="checkbox"/> Have diarrhea often? |
| <input type="checkbox"/> | <input type="checkbox"/> Take laxative/enema regularly? | <input type="checkbox"/> | <input type="checkbox"/> Leak gas by accident? |
| <input type="checkbox"/> | <input type="checkbox"/> Have very strong urge to move your bowels? | | |

How often do you move you 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

Print Name

Witness Signature

Print Name