Baptist Health System

HEALTHLINK

PATIENT NAME:_____

DATE OF BIRTH:_____

HealthLink Consent for Treatment and Medical History

Patient Name:_____ Social Security #:_____

Date of Birth (DOB):_____ Age:_____ Date of surgery/Injury:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Primary Phone:_____ Secondary Phone:_____

E-mail:_____

Primary Person on Insurance (If not patient):_____ DOB:_____

Referring Physician:_____ Primary Care Physician:_____

Emergency Contact:_____

Emergency Contact Phone:_____ Relationship:_____

Is your injury/condition due to a car accident? ☐Yes ☐No Receiving Home Health? ☐Yes ☐No

Appointment Reminder Option (Check One): _____Call _____Text message

Consent to Medical and Related Health Care: I consent to the admission to Healthlink, an outpatient facility of Baptist Health System, referred to as "Facility", and consent to treatment and procedures that my doctor thinks are needed. I also understand that the delivery of health care services and treatment may involve risks of injury or even death. No guarantees are made to me regarding the result of examination or treatment at Healthlink.

Payment Agreement/Assignment of Benefits: I agree (on behalf of the patient, and, if I am the parent of a minor child, also on my own behalf) to pay all charges and expenses for services at the rates set by the Facility, unless a different rate is set by the Facility's contract with my managed care or insurance company. I understand that failure to pay these charges within 45 days after billing may result in referral to an agency or attorney for collection, in which case I agree to pay reasonable attorneys' fees and collection expenses in addition to the balance of the account. I agree that if the account results in a credit balance, this credit balance will be applied to any other debt I owe to the hospital and the balance refunded to me.

I assign to the Facility all (i) rights in benefits or compensation otherwise payable to me by any insurance company (this includes, but is not limited to, health or medical insurance coverage, auto or homeowners' insurance including uninsured motorist coverage and personal injury protection) and any other payor, and (ii) rights, claims and causes of action against anyone who may be financially responsible for the injury or illness which caused or contributed to my hospitalization, including funds from any settlement. I understand that it is not the Facility's responsibility to file claims or file suit on my behalf. It is my responsibility, within the applicable time limits, to seek all insurance reimbursement, obtain all proper pre-authorizations, file any lawsuits against any financially responsible parties, and appeal any denials. I understand that my failure to take these actions may result in a denial of reimbursement or money otherwise due me, in which case I would still be responsible for the full amount of the Facility bills.

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Medicare/Medicaid Payment: If I have coverage through Medicare or Medicaid, I certify that the information given by me in assigning payment under Medicare or Medicaid is correct. I request that payment of authorized Medicare or Medicaid benefits be paid directly to this Facility on my behalf. I authorize this Facility to release any information about me that is necessary to act on this request for payment.

Attendance Policy: We respectfully request 24 hours advance notice of appointment cancellations. Consistent care is important for progress. If you have three (3) cancellations or two (2) no-shows, you will be discharged as a patient. Please speak to your therapist if extenuating circumstances arise.

Teaching: Students, residents, postgraduate fellows, nursing and other clinical students may participate in my care as a part of the clinical education or research program of the hospital or the Facility under appropriate supervision. Unless I notify the Facility that I do not want to participate in these educational programs, I agree that trainees may participate in and/or provide care to me while I am a patient at the Facility.

Personal Property: As a patient, I am encouraged to leave personal items at home. I have been informed by the Facility that the clinic maintains a place for personal effects. I understand that the Facility accepts no responsibility for loss of any personal effects that I or others bring to the clinic for me. I release this Facility and its agents for damage to or loss of my property.

Notice of Electronic Check Conversion: If I provide a check as payment, I authorize this Facility to use information from my check to make a one-time electronic funds transfer (EFT) from my account or to process the payment as a check transaction. If this Facility uses information from a check to make an EFT, the funds may be withdrawn from my checking account the same day.

Advanced Directives:

Patient has an advanced directive or living will: ☐No ☐Yes

If yes, copy provided? ☐No ☐Yes

Patient has Medical Durable Power of Attorney: ☐No ☐Yes

If yes, copy provided? ☐No ☐Yes

Patient has designated a Health Care Surrogate: ☐No ☐Yes

If yes, copy provided? ☐No ☐Yes

Name of designated Health Care Surrogate: _____

Phone Number: _____Relationship to patient: _____

I would like to receive further information about Living Wills and other advanced directives: ☐No ☐Yes

Patient Rights and Responsibilities: I received Patient Rights and Responsibilities information explaining my rights and my responsibilities as a patient in this Facility, including how to file a complaint and grievance.

Consent to Contact:

I consent and authorize this Facility, as well as any of their related entities, agents, or contractors, including but not limited to schedulers, debt collectors, and other contracted staff (any or all of these is referred to as “Provider”) to use automated telephone dialing systems, text messaging systems and electronic mail to (1) provide messages (including prerecorded messages or text messages) to me about my account, payment due dates, missed payments, information for or related to medical goods and/or services provided, exchange information, changes to the health care law, health care coverage, care follow-up, and other healthcare information or (2) provide telemarketing messages (including pre-recorded messages) during a call or via text message that delivers a “health care” message made by, or on behalf of, a “covered entity” or its “business associate,” as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103.

Telephone messages may be played by a machine automatically when the telephone is answered, whether answered by me or someone else. These messages may also be recorded by my answering machine. I give the Provider permission to call or send a text message to any telephone number. I give the Provider permission to play pre-recorded messages or send text messages with information about my transactions over the phone, and understand that such information may not be encrypted or secure.

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I promise that, unless I indicate otherwise, I own or customarily use the telephone numbers I give the Provider. I also promise to notify the Provider in writing within 30 days if I change phone number(s). I understand that Provider will continue to use the number I provide unless I provide notice of a change, and, therefore, failure to notify Provider may result in missed or delayed communications. I also give the Provider permission to communicate such information to me via electronic mail, and understand that such information may not be encrypted or secure.

I agree that the Provider will not be liable to me for any calls or electronic communications, even if information is communicated to an unintended recipient (including, for example, contacts to a previous number that I have not notified the Provider is no longer used by me).

I understand that, when I receive such calls or electronic communications, I may incur a charge from the company that provides me with telecommunications, wireless and/or Internet services. I agree that the Provider has no liability for such charges. I understand that consent to receive calls/messages is not a condition of receiving medical services.

I also understand that I may revoke my consent to contact at any time by directly contacting Provider or utilizing the opt–out method that will be identified in the applicable communication.

I have read and may request a copy of this form. I am the patient, the patient's legal representative, or am authorized by the patient as the patient's general agent to act on his or her behalf to accept the terms of this form. I understand and accept the terms of this Consent for Treatment form. If I have any questions, I have had an opportunity to ask questions about anything I don't understand.

Printed Name of Patient	Signature of Patient/Patient's Agent or Representative	Date	Time
Patient's DOB	Clinic Representative/Employee#	Date	Time

Translator: I have accurately and completely read the document to the patient or patient's representative in the language requested by the patient or patient's representative.

Translator	Date / Time
Witness	Date / Time

PATIENT NAME:_____

DATE OF BIRTH:_____

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGMENT

A **Notice of Privacy Practices (NPP)** is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

_____ _____

Name of Patient Signature of Patient

_____ / _____ / _____

Date Signed

_____ _____

Name Patient's Personal Representative Signature of Patient's Personal Representative

_____ / _____ / _____

Date Signed

FOR INTERNAL USE ONLY

_____ _____

Name of Employee Signature of Employee

If applicable, reason patient's written acknowledgment could not be obtained:

☐ Patient was unable to sign.
☐ Patient refused to sign.
☐ Other _____

____ - ____ (Version: As noted on NPP) ____/ ____/ ____ (Date: As noted on NPP)

PATIENT NAME:_____

DATE OF BIRTH:_____

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care or financial matters. This is to achknowledge that you authorize HEALTHLINK to disclose your PHI to the following individuals (check all that apply):

Name:_____ Relationship to Patient:_____

Telephone:()_____ Email:_____

Types of Information: ☐ Appointment Reminders ☐ Financial ☐ Other:

Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Secure Email ☐ Other:

Name:_____ Relationship to Patient:_____

Telephone:()_____ Email:_____

Types of Information: ☐ Appointment Reminders ☐ Financial ☐ Other:

Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Secure Email ☐ Other:

_____	_____	_____	_____
Print Name of Patient	Signature of Patient/Patient's Agent or Representative	Date	Time
_____	_____	_____	_____
Patient's DOB	Clinic Representative/Employee #	Date	Time

PATIENT NAME:_____

DATE OF BIRTH:_____

PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

Informed consent for pelvic floor treatment: I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunction includes, but 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 condition, reflexes, muscle tone, length, strength, 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 be 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.

Potential risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my therapist.

Potential benefits: I may experience improvements in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and dis comfort. I should gain a greater knowledge about managing my condition and the resources available to me.

I have informed my therapist of any condition that may limit my ability to be evaluated or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapist.

_____	_____	_____	_____
Printed Name of Patient	Signature of Patient/Patient's Representative	Date	Time

_____	_____	_____
Clinic Representative/Employee#	Date	Time

PATIENT NAME:_____

DATE OF BIRTH:_____

Patient Pelvic History

1. Describe the current problem that brought you here?_____
_____

2. When did your problem first begin? _____

3. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date_____
_____

4. Since that time is it: staying the_____same_____getting worse_____getting better
Why or how?_____

5. What are your treatment goals/concerns?_____
_____

6. What is your pain rating on a scale of 0-10 scale (10 being the worst)._____Describe the nature of the pain
(i.e. constant burning, intermittent, aching)_____

7. Describe previous treatment/exercises _____

8. Activities/events that cause or aggravate your symptoms. Check all that apply.

_____ Sitting greater than_____minutes
_____ Walking greater than_____minutes
_____ Standing greater than minutes

_____ Changing positions (ie. - sit to stand)
_____ Light activity (light housework)

_____ Vigorous activity/exercise (run/weight lift/jump)
_____ Sexual activity
_____ Other, please list:_____

_____ With cough/sneeze/straining
_____ With laughing/yelling
_____ With lifting/bending

_____ With cold weather
_____ With triggers -running water/key in door

_____ With nervousness/anxiety
_____ No activity affects the problem

9. What relieves your symptoms?_____
_____

Do you have the following, since onset of your current pelvic symptoms?

Y/N	Fever/Chills	Y/N	Malaise (Unexplained tiredness)
Y/N	Unexplained weight change	Y/N	Unexplained muscle weakness
Y/N	Dizziness or fainting	Y/N	Night pain/sweats
Y/N	Change in bowel or bladder functions	Y/N	Numbness / Tingling
Y/N	Other /describe_____		

_____

PATIENT NAME:_____

DATE OF BIRTH:_____

Have you ever had any of the following conditions or diagnoses? circle all that apply /describe

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple sclerosis	Allergies-list below
Ankle swelling	Head Injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/ Hyperthyroid
Low back pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug problem	Arthritic conditions	Kidney disease
Childhood bladder problems	Stress fracture	Irritable Bowel Syndrome
Depression	Rheumatoid Arthritis	Hepatitis HIV/AIDS
Anorexia/bulimia	Joint Replacement	Sexually transmitted disease
Smoking history	Bone Fracture	Physical or Sexual abuse
Vision/eye problems	Sports Injuries	Raynaud's (cold hands and feet)
Hearing loss/problems	TMJ/ neck pain	Pelvic pain

Other/Describe: _____

Surgical /Procedure History

Y/N	Surgery for your back/spine	Y/N	Surgery for your bladder/prostate
Y/N	Surgery for your brain	Y/N	Surgery for your bones/joints
Y/N	Surgery for your female organs	Y/N	Surgery for your abdominal organs

Other/describe: _____

Ob/Gyn History (females only)

Y/N	Childbirth vaginal deliveries # _____	Y/N	Vaginal dryness
Y/N	Episiotomy # _____	Y/N	Painful periods
Y/N	C-Section # _____	Y/N	Menopause - when? _____
Y/N	Difficult childbirth # ____	Y/N	Painful vaginal penetration
Y/N	Prolapse or organ falling out	Y/N	Pelvic pain

Other /describe:_____

Males only

Y/N	Prostate disorders	Y/N	Erectile dysfunction
Y/N	Shy bladder	Y/N	Painful ejaculation
Y/N	Pelvic pain		
Y/N	Other /describe:_____		

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Problems

Y/N	Trouble initiating urine stream	Y/N	Blood in urine
Y/N	Urinary intermittent /slow stream	Y/N	Painful urination
Y/N	Trouble emptying bladder	Y/N	Trouble feeling bladder urge/fullness
Y/N	Difficulty stopping the urine stream	Y/N	Current laxative use
Y/N	Trouble emptying bladder completely	Y/N	Trouble feeling bowel/urge/fullness
Y/N	Straining or pushing to empty bladder	Y/N	Constipation/straining
Y/N	Dribbling after urination	Y/N	Trouble holding back gas/feces
Y/N	Constant urine leakage	Y/N	Recurrent bladder infections

Y/N Other/describe: _____

1. Frequency of urination: awake hour's_____times per day, sleep hours_____times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?_____ minutes, _____ hours,_____not at all
3. The usual amount of urine passed is:____small_____medium_____large.
4. Frequency of bowel movements_____ times per day, _____times per week
5. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? _____ minutes,_____hours,_____not at all.
6. If constipation is present describe management techniques_____
7. Average fluid intake (one glass is 8 oz or one cup)_____ glasses per day.

Of this total how many glasses are caffeinated?_____glasses per day.

8. Rate a feeling of organ “falling out” / prolapse or pelvic heaviness/pressure:

___ None present

___ Times per month (specify if related to activity or your period)

___ With standing for_____minutes or_____hours.

___With exertion or straining

___Other

Skip questions if no leakage/incontinence

9a. Bladder leakage - number of episodes

___ No leakage

___ Times per day

___ Times per week

___ Times per month

___ Only with physical exertion/cough

9b. Bowel leakage - number of episodes

__ No leakage

__ Times per day

__ Times per week

__ Times per month

__ Only with physical exertion/cough

10a. On average, how much urine do you leak?

___ No leakage

___ Just a few drops

___ Wets underwear

___ Wets outerwear

___ Wets the floor

10b. How much stool do you lose?

__ No leakage

__ Stool staining

__ Small amount in underwear

__ Complete emptying

11. What form of protection do you wear? (Please complete only one)

___ None

___ Minimal protection (Tissue paper/paper towel/pantishields)

___ Moderate protection (absorbent product, maxipad)

___ Maximum protection (Specialty product/diaper)

___ Other _____

On average, how many pad/protection changes are required in 24 hours?_____# of pads

To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services with Baptist Health System.

Patient signature: _____ Date: _____ Time: _____

Therapist signature: _____ Date: _____ Time: _____

Baptist Health System
HEALTHLINK

PATIENT NAME:_____

DATE OF BIRTH:_____

OUTPATIENT HOME MEDICATION LIST

Height (in)_____ Weight (lbs)_____ kg_____ Diabetes ☐ Y ☐ N Dialysis ☐ Y ☐ N	Allergies / Intolerance(s)	Reaction(s)
FEMALES ONLY Pregnant ☐ Y ☐ N Breastfeeding ☐ Y ☐ N		

Source: ☐ As stated by patient / family ☐ Outpatient pharmacy ☐ Physician office list ☐ H & P ☐ Nursing home / Home health

Disposition of Medications: ☐ Sent home with patient/family (name)_____

DIRECTIONS: List all prescription and non-prescription medications used prior to this visit, including: aspirin, insulin, eye drops, inhalers, nutritional and herbal supplements and all pumps or patches. If more than one form is required to document all medications, indicate the number of forms in the space listed on line 15.

DO NOT USE ABBREVIATIONS:

iu	qd	MS	u
MgSO4	qod	MS04	

With a zero always lead and never follow a decimal point.
For example use (Xmg) not (X.0mg), (0.Xmg) not (Xmg).

	Drug Name	Dose (strength)	Route	Frequency	Indication	Initials	DC Date	New Date
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.	_____ Number of forms required to document all medications. This is page _____.							

Not taking any home medication(s)

Form reviewed by: (Signature/Title)	Emp #:	Date:	Time:

Initials	Signature/Title	Emp #	Date	Time