Provenance
REHABILITATION
specialists in pelvic health & wellness

Alpharetta / North Fulton
318 Maxwell Road, Suite 100
Alpharetta, GA 30009
(678) 819-8720, (678) 819-8721 (fax)

Welcome to Provenance Rehabilitation!

Thank you for entrusting us with your pediatric physical therapy needs. One of our main priorities is to provide a setting that is comfortable to you. Our goal for your first visit is for you to leave with a sense of hope and optimism about your condition and the plan of care that we establish with you and your child.

We look forward to having your child as a patient.

What makes Provenance Rehabilitation unique?

- All patients receiving treatment at Provenance Rehabilitation have some form of pelvic pain and/or dysfunction (incontinence, organ prolapse, painful intercourse, or pregnancy-related conditions).
- Our therapists are thoroughly trained with over 25 years of experience, capable of providing the service and care that you need.
- We treat children, women, and men who are experiencing pelvic-related issues.
- Our patients are referred from health care providers from all over Georgia, the Mayo Clinic in Florida, and from specialists in other states. We also have a large percentage of patients who refer themselves after finding us on the internet.
- Treatment always combines education about the condition, manual therapy, exercises, and home program instruction.
- One patient is seen at a time in a private room rather than an open setting. Our facilities have a strong focus on patient privacy and professionalism.
- We have a Facebook & Instagram page along with our website where we post articles about pelvic health conditions and patient stories that are relevant to our practice.

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Patient's Name: _____ DOB:_____Age:____

Address:_____

Phone:_____Parent's E-mail Address:_____

Emergency Contact:_____Phone:_____

Referred by:_____Phone:_____

Other providers involved in the condition:

_____Phone:_____

_____Phone:_____

_____Phone:_____

Brief Description of Condition or Diagnosis:_____

_____

The fees have been discussed with me, and I understand that I am to pay for physical therapy services provided at the conclusion of each visit unless other arrangements have been agreed upon. I understand that it is my responsibility to find out about my insurance policy's out-of-network reimbursement for PT services. I will be provided a superbill that includes all necessary information for me to send to my insurance company for potential reimbursement.

Patient Name (Please Print): _____

Patient Signature (if cannot sign, parent please sign next line below):

_____ Date: _____

Signature of parent or guardian (if applicable): _____

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Cancellation & No-Show Policy

We strive to schedule all appointments as efficiently as possible in order to have adequate time with each of our patients. We request that you notify our office immediately once you realize you will not be able to keep your appointment or if you may be late for any reason.

If you need to cancel or reschedule your appointment, we ask that you please do so at least **24 hours before your scheduled office visit to avoid paying a $75.00 fee**.

We will ask you to provide a credit card number over the phone for us to use for collection of the cancellation fee if ever needed. Your credit card information will be stored safely in our electronic documentation system (not on paper).

Our policy is to charge $150.00 on the day of your reserved appointment if we are not given sufficient notification of cancellation or request to reschedule that appointment. Please understand that this policy is strictly enforced in our efforts to accommodate patients who are on a waiting list to receive our services.

We will always alert you before charging any fee to your card.

Thank you very much for your attention to this matter. Please sign below that you have read and understand our cancellation and no-show policy:

Patient Name (Please Print):_____

Patient Signature (if cannot sign, parent please sign next line below):

_____ Date: _____

Signature of parent or guardian (if applicable): _____

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Alpharetta / North Fulton - Directions to our Facility

From GA-400:

- Take Old Milton Pkwy Exit #10 or Haynes Bridge Exit #9 and head WEST towards downtown Alpharetta. If coming from Haynes Bridge, turn left on to Old Milton Pkwy.
- Turn left at Highway 9 to head South.
- Take a left prior to the Maxwell Road / Roswell Street red light into Colony Park
- Our suite number is #100 and there's a map as soon as you enter the complex.

From Downtown Alpharetta:

- Head South past downtown Alpharetta and continue through Old Milton Parkway.
- Take a left prior to the Maxwell Road / Roswell Street red light into Colony Park
- Our suite number is #100 and there's a map as soon as you enter the complex.

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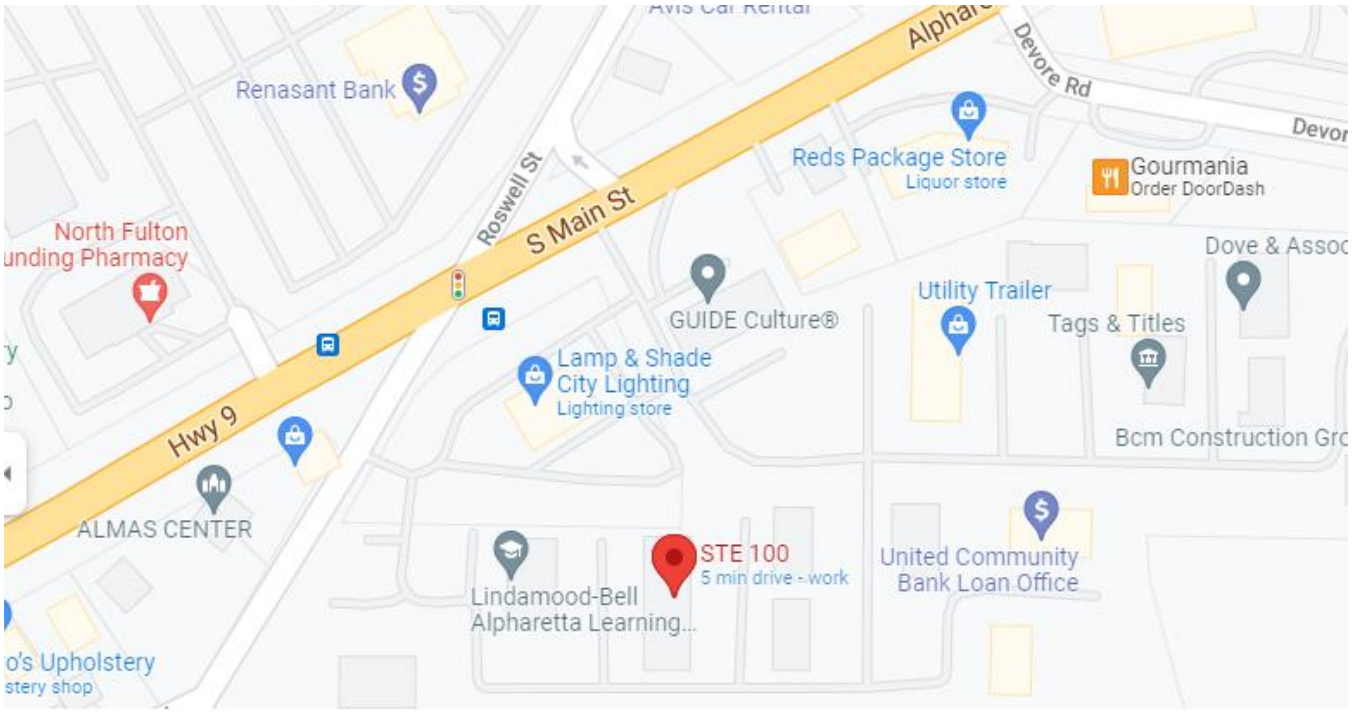
Alpharetta / North Fulton Location



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PEDIATRIC CONSENT FOR EVALUATION AND TREATMENT

Informed consent for treatment:

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

I also acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, difficulty with bowel or bladder functions, or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform a pelvic floor muscle examination. This examination is performed primarily by observing and/or palpating the external perineal region. No internal examination is done. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, and function of the pelvic floor region.

Treatment may include, but not be limited to the following: observation, palpation, biofeedback and/or electrical stimulation, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction. Treatment may also include _____
_____

Potential risks: I may experience an increase in my current level of pain or discomfort if any, 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 physical therapist.

Potential benefit: I may experience an improvement 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 discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Release of medical records:
I authorize the release of my medical records to my physicians/primary care provider or insurance company.

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Cooperation with treatment:
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 to cooperate with and carry out the home physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

No warranty: I understand that the therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of treatment for my condition and will discuss all treatment options with me before I consent to treatment.

I have informed my therapist of any condition that would limit my ability to have and evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists and therapy assistants and technicians of Tina McGinley, PT, DPT

Patient Name (Please Print): _____

Patient Signature (if cannot sign, parent please sign next line below):

_____ Date: _____

Signature of parent or guardian (if applicable): _____

Due to privacy regulations, we require your permission to email you and to leave messages on your voicemail (re: appointment reminders and/or rescheduling appointments) or with any individual who answers the number you provide, identifying ourselves as "Provenance Rehabilitation."

Do we have your permission to leave such messages and to email you?
→ Yes OR No Initials: _____