CREATIVE THERAPEUTICS
PHYSICAL THERAPY

2763 E. Shaw Ave. Suite #102 | Fresno, CA 93710 | (559) 294-8112 | Fax (559) 294-7805

Sandra Bausman, PT, WCS
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Welcome to Creative Therapeutics Physical Therapy. Please arrive 10 minutes before your appointment time. Thank you.

**Please Note:**

1. It is this office's protocol to have an RX/Referral from your doctor or dentist according to the diagnosis you will be treated for, in order for your visits to be processed through your health insurance.

2. If you are receiving physical therapy treatment at another Clinic, please arrange these appointments on different days when you have your appointment here. It can affect how your insurance plan may or may not pay if you have two physical therapy sessions on the same day.

As a courtesy to others with allergy sensitivities, we kindly ask you to please refrain from wearing colognes or perfumes during your visit here.

***A fee of $75.00 will be charged for failure to cancel an initial evaluation appointment without a 24 hour notice. A fee of $35.00 will be charged for failure to cancel a follow-up appointment without a 4 hour notice.***

If you have any questions, please feel free to call our office.

Thank you.
Creative Therapeutics Physical Therapy


# FINANCIAL POLICY

Communication with our clients regarding our financial policy assists us in providing the best possible service to you. Please read the following. Your signature is required at the bottom of the page.

***PRIVATE PAY*** – Full payment is required when services are rendered to continue treatment.

***DEDUCTIBLE, CO-PAYMENT AND/OR CO-INSURANCE*** – We will be contacting your health insurance to verify your coverage. It is important to remember that what the insurance company tells us is not a GUARANTEE of payment from them. If you have a deductible remaining, we ask a payment of $25.00 at each appointment. If you have a co-payment due at each appointment, the amount of your deductible can be discussed in advance of your treatment.

***PURCHASING PRODUCTS*** – Payment for all products are the patient's responsibility and due at time of purchase.

***WORKERS' COMP*** – Only certain pre-authorized insurance carriers are accepted

***AUTO*** – We only accept auto claims if you carry at least $5,000.00 Medical Payments on your insurance policy and it has not been used during the course of this auto accident for other medical appointments. We DO NOT accept LIENS. If your auto insurance does not pay in a timely manner, or you are waiting until the claims are settled, you are responsible for payment at the time of service.

## AGREEMENT TO PAY

_____I understand that the Agreement with my insurance company is an Agreement between them and me. I take full responsibility for payment of all charges for professional services rendered. I understand the financial policy outlined above. I understand that I am responsible for all charges regardless of my existing medical coverage. (Please initial above if you understand these statements).

***A FEE OF $35.00 WILL BE CHARGED FOR NOT CANCELING A FOLLOW-UP APPOINTMENT WITH AT LEAST A 4 HOUR NOTICE. $75.00 WILL BE CHARGED FOR NOT CANCELING AN INITIAL APPOINTMENT WITH AT LEAST A 24 HOUR NOTICE.***

**CONSENT FOR TREATMENT / RELEASE OF INSURANCE ASSIGNMENT MEDICAL INFORMATION:**

YES____NO____I authorize the therapy services that the provider feels necessary or advisable in conjunction with my referral.

YES____NO____I assign payment of medical benefits directly to Creative Therapeutics P.T., Inc. (C.T.P.T., Inc.)

YES____NO____I hereby authorize C.T.P.T., Inc. to release to my insurance company or medical provider any medical records or information concerning the treatment to obtain reimbursement on my behalf for the treatment or service provided by C.T.P.T., Inc. I understand that I may revoke the consent to release information to third parties at any time and that the provision of services is not conditioned on my agreement to disclose information to the parties. If I revoke my consent, I will be responsible for paying all services rendered by C.T.P.T., Inc.

I HAVE READ, UNDERSTAND AND AGREE TO THIS FINANCIAL AGREEMENT.

SIGNATURE DATE


# NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

## LEGAL DUTY

*Creative Therapeutics P.T., Inc.* is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

## USES AND DISCLOSURES OF HEALTH INFORMATION

*Creative Therapeutics P.T., Inc.* uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, *Creative Therapeutics, P.T., Inc.* may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

*Creative Therapeutics P.T., Inc.* may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, *Creative Therapeutics, P.T., Inc.*'s policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop further disclosures at any time.

*Creative Therapeutics P.T., Inc.* may change its policy at any time. When changes made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

## PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specially authorized by you, when required by law or in emergency circumstances. *Creative Therapeutics P.T., Inc.* will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

## CONCERNS AND COMPLAINTS

If you are concerned that *Creative Therapeutics P.T., Inc.* may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Practice Administrator at the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. For further information on *Creative Therapeutics P.T., Inc.*'s health information practices or if you have a complaint, please contact the following person:

KATINKA YEPEZ, PRACTICE ADMINISTRATOR
*2763 E. Shaw Ave., #102 Fresno, CA 93710*
Telephone: 559-294-8112 FAX: 559-294-7805


## PATIENT INFORMATION CONSENT FORM

I have read and fully understand *Creative Therapeutics Physical Therapy, Inc*.'s Notice of Information Practices. I understand that *Creative Therapeutics Physical Therapy, Inc.* may use or disclose my personal information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services probed and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that *Creative Therapeutics Physical Therapy, Inc.* will consider requests for restrictions on a by case bases, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in *Creative Therapeutics Physical Therapy, Inc.'s* Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I have requested and/or been given a copy of *Creative Therapeutics Physical Therapy, Inc.'s* Notice of Information Practices, which describes how much my health information is used and shared. I may obtain a copy by contacting the Privacy Official or by visiting the web site at www.creativetherapeutics.com.

**MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE BEEN PROVIDED WITH A COPY OF THE NOTICE OF INFORMATION PRACTICES.**

_____
Patient Name

_____
Signature

_____
Date

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www.creativetherapeutics.com

# Men's Pelvic Pain Assessment

Date: _____

**Initial History and Physical Examination**

This assessment form is intended to assist the clinician with the initial patient assessment and is not meant to be a diagnostic tool.

**Patient Information**

Name: _____ DOB: _____

Address: _____ City: _____ ZIP code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Referring Provider: _____ PC Provider: _____

Primary Insurance: _____

Insured's name and D.O.B.: _____

Secondary Insurance: _____

Have you had physical therapy this year? Yes___ No___ If Yes, how many visits this current year and when? _____

For what problem? _____

_____

**Medical History**

Please list any medical problems/diagnoses: (Use a separate paper if needed.)

_____

_____

_____

Allergies (medications, food, latex, etc.): _____

Have you had major accidents, such as a falls or a back injury? ☐ Yes ☐ No

Have you ever been treated for depression? ☐ Yes ☐ No Treatments: ☐ Medication ☐ Hospitalization ☐ Psychotherapy

**Demographic Information**

Are you (check all that apply):

☐ Married ☐ Single ☐ Committed Relationship ☐ Domestic Partner ☐ Same Sex Relationship

What type of work are you trained for? _____

What type of work are you doing? _____

## Surgical History

Please list all surgical procedures you have had related to this pain:

| Year | Procedure | Surgeon | Findings |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please list all other surgical procedures:

| Year | Procedure |
|---|---|
| | |
| | |
| | |
| | |
| | |

## Medications

Please list all medications you are taking and the provider who prescribed them. (Use a separate paper if needed):

| Medication/Dose | Provider | Does it help? |
|---|---|---|
| | | O Yes O No O Currently taking |
| | | O Yes O No O Currently taking |
| | | O Yes O No O Currently taking |
| | | O Yes O No O Currently taking |
| | | O Yes O No O Currently taking |

## Gastrointestinal/Eating

Do you have nausea? ☐ No ☐ With pain ☐ Taking medication ☐ With Eating ☐ Other

Do you have vomiting? ☐ No ☐ With pain ☐ Taking medication ☐ With Eating ☐ Other

Have you ever had an eating disorder such as anorexia or bulimia? ☐ Yes ☐ No

Are you experiencing rectal bleeding or blood in your stool? ☐ Yes ☐ No

Do you have increased pain with bowel movements? ☐ Yes ☐ No

Change in frequency of bowel movement? ☐ Yes ☐ No

Change in appearance of stool or bowel movement? ☐ Yes ☐ No

Does your pain improve after completing a bowel movement? ☐ Yes ☐ No

## Health Habits

How often do you exercise? ☐ Rarely ☐ 1-2 times weekly ☐ 3-5 times weekly ☐ Daily

What is your caffeine intake (number of cups per day, including coffee, teas, soft drinks, etc.)?

☐ 0 ☐ 1-3 ☐ 4-6 ☐ 6+

What is your water intake (number of cups per day.)?

☐ 0 ☐ 1-3 ☐ 4-6 ☐ 6+

Do you smoke? ☐ Yes ☐ No If "yes", for how many years?____ cigarettes per day?_____

Do you drink alcohol? ☐ Yes ☐ No Number of drinks per week_____

How would you describe your diet? (Check all that apply)

☐ Well balanced ☐ Vegan ☐ Vegetarian ☐ Fried Food ☐ Special Diet ☐ Other: _____

**Information about your problem or pain**

Please describe the issue that brings you to physical therapy (use a separate piece of paper, if needed):

_____

_____

_____

_____

_____

What do you think is causing your problem/pain?

_____

Is there an event that you associate with the onset of your problem/pain? Yes No If so, what? _____

**Urinary Symptoms**

Do you experience any of the following?

| | |
|---|---|
| Loss of urine when coughing, sneezing, or laughing? | ☐ Yes ☐ No |
| Difficulty passing urine? | ☐ Yes ☐ No |
| Frequent bladder/prostate infections? | ☐ Yes ☐ No |
| Blood in the urine? | ☐ Yes ☐ No |
| Still feeling full after urination? | ☐ Yes ☐ No |
| Having to void within minutes of voiding? | ☐ Yes ☐ No |

**Please circle the best answer that describes your bladder and bowel function and symptoms.**

| | | | | | |
|---|---|---|---|---|---|
| How many times do you go to the bathroom **DURING THE DAY** (to void or empty your bladder? | 3-6 | 7-10 | 11-14 | 15-19 | 20 or more |
| How many times do you go to the bathroom **AT NIGHT** (to void or empty your bladder)? | 0 | 1 | 2 | 3 | 4 or more |
| How many times do you go to the bathroom **DURING THE DAY (bowel movement)**? | 0 | 1-2 | 3-4 | 5-6 | 6+ |
| How many times do you go to the bathroom **AT NIGHT** (bowel movement)? | 0 | 1 | 2 | 3 | 4 or more |
| If you get up at night to void or empty your bladder does it bother you? | Never | Mildly | Moderately | Severely | |
| Are you sexually active? | Yes | No | | | |
| If you are sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse? | Never | Occasionally | Usually | Always | |
| Do you have pain associated with your bladder or in your pelvis (lower abdomen, penis, testicles, urethra, perineum)? | Never | Occasionally | Usually | Always | |
| Do you have urgency after voiding? | Never | Occasionally | Usually | Always | |
| If You have pain, is it usually? | Never | Mild | Moderate | Severe | |
| If you have urgency, is it usually | Never | Mild | Moderate | Severe | |

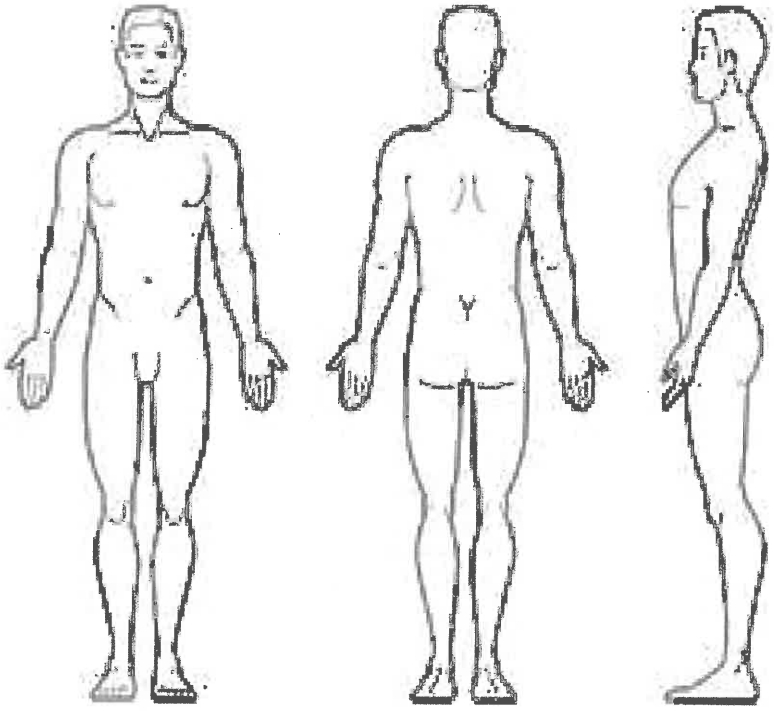
**Pain only**

For each of the pain symptoms please "bubble in" your level of pain over the last month using a 10-point scale:

0 – no pain  10 – The worst pain imaginable

| How would you rate you pain? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Deep pain with intercourse | O | O | O | O | O | O | O | O | O | O | O |
| Pain in groin when lifting | O | O | O | O | O | O | O | O | O | O | O |
| Pelvic pain lasting hour/days after intercourse | O | O | O | O | O | O | O | O | O | O | O |
| Pain when bladder is full | O | O | O | O | O | O | O | O | O | O | O |
| Muscle/joint pain | O | O | O | O | O | O | O | O | O | O | O |
| Pain with ejaculation | O | O | O | O | O | O | O | O | O | O | O |
| Pain with erection | O | O | O | O | O | O | O | O | O | O | O |
| Burning pain after sex | O | O | O | O | O | O | O | O | O | O | O |
| Pain with urination | O | O | O | O | O | O | O | O | O | O | O |
| Backache | O | O | O | O | O | O | O | O | O | O | O |
| Migraine/ headache | O | O | O | O | O | O | O | O | O | O | O |
| Pain with sitting | O | O | O | O | O | O | O | O | O | O | O |
| Pain with bowel movements | O | O | O | O | O | O | O | O | O | O | O |

Please Shade areas of pain and write a number from 1-10 at the site(s) of pain. (10 = the most severe pain imaginable)



Right Left  Left Right

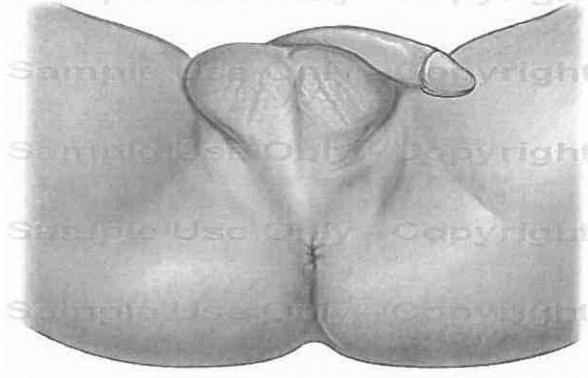
***Perineal Pain/Testicular/Penis***

(Pain outside and around the penis/testicles/anus)

If you have pain, shade the painful areas and write the number 1-10 at the painful sites
(10= most severe pain imaginable)

Is your pain relieved by sitting on a commode seat? ☐ Yes ☐ No

Right Left



**The words below describe average pain. Place a check mark in the column which represents the degree to which you feel that type of pain. Please limit yourself to a description of pain in your pelvic area only.**

**What does your pain feel like?**

| Type | None (0) | Mild (1) | Moderate (2) | Severe (3) |
|---|---|---|---|---|
| Throbbing | | | | |
| Shooting | | | | |
| Stabbing | | | | |
| Sharp | | | | |
| Cramping | | | | |
| Gnawing | | | | |
| Hot burning | | | | |
| Aching | | | | |
| Heavy | | | | |
| Tender | | | | |
| Splitting | | | | |
| Tiring-Exhausting | | | | |
| Sickening | | | | |
| Fearful | | | | |
| Punishing-Cruel | | | | |

**Information about your pain**

What types of treatments / providers have you tried in the past for your pain?

| | | |
|---|---|---|
| O Acupuncture | O Homeopathic Medicine | O Physical Therapy |
| O Anesthesiologist | O Lupron or Zoladex | O Psychotherapy |
| O Anti-seizure medication | O Massage | O Psychiatrist |
| O Antidepressants | O Meditation | O Rheumatologist |
| O Biofeedback | O Narcotics | O Skin Magnets |
| O Botox Injection | O Naturopathic | O Surgery |
| O Danazol (Danocrine) | O Nerve Blocks | O Tens unit |
| O Gastroenterologist | O Neurosurgeon | O Trigger point injections |
| O Family Practitioner | O Nonprescription Medicines | O Urologist |
| O Herbal Medicine | O Nutrition/Diet | O Other:_____ |

**What physicians or health care providers have evaluated or treated you for your pelvic health issue?**

| Physician/Provider | Specialty | City, State, Phone |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Coping Mechanisms**

What helps your pain? ☐ Meditation ☐ Relaxation ☐ Laying down ☐ Music
☐ Massage ☐ Heating pad ☐ Hot bath ☐ Pain Medication
☐ Laxative/Enema ☐ Injection ☐ TENS Unit ☐ Bowel Movement
☐ Emptying Bladder ☐ Nothing ☐ Ice ☐ Other:_____

What makes your pain worse? ☐ Intercourse ☐ Ejaculation ☐ Stress ☐ Full Meal ☐ Bowel Movement
☐ Full bladder ☐ Urination ☐ Standing ☐ Walking ☐ Exercise
☐ Time of Day ☐ Weather ☐ Contact with clothing ☐ Coughing/ Sneezing
☐ Not related to anything ☐ Other_____

Of all the problems or stresses in your life, how does your pain compare in importance?
☐ Most important ☐ Just one of many problems

**Sexual and Physical Abuse History**

Have you ever been the victim of emotional abuse? This can include being humiliated or insulted.
☐ Yes ☐ No
If yes, what age? (13 and younger) (14 and over)

Have you ever been a victim of physical/sexual abuse?
☐ Yes ☐ No
If yes, what age? (13 and younger) (14 and over)

## Consent for Internal Pelvic Floor Examination

I, (print name) _____ give my consent for Sandra Bausman, PT, WCS, Nancy Larson, PT,WCS or Jessica Delgado PT, DPT to do a rectal examination for the purpose of evaluation of my condition and therapeutic treatment.

1. The purpose, procedure, and risks of this procedure 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 any discomfort, or unusual symptoms during the procedure.
4. I have the option of having a second person in the room during the procedure and ____ choose/____ refuse this option.

I have read this consent form and understand its terms, and I am signing it knowingly and voluntarily.

Patient Signature _____Date_____