



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 \$50.00 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. All dates of service are billed promptly; however, you are responsible to pay in advance for your deductible if it has not been met. Co-payment and/or co-insurance are required to be paid at the time of service.

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

## 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).

### 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.**

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SIGNATURE

DATE



## Office No-Show and Late Arrival Policies

**No-Show/Late Cancellations:** Appointment time slots are precious and very much in demand for our office. In an effort to serve you better, we ask for proper notice for any cancellation. **Patients failing to provide at least a 24-hour notice will be charged \$75.00 for the initial evaluation. Follow-up visits not cancelled 4 hours prior will be subject to a late cancellation fee of \$50.00.**

**Late Arrivals:** We make every effort to be on time for all our appointments. Unfortunately, when even one patient arrives late, it can throw off the entire schedule for that session. In addition, rushing or “squeezing in” an appointment shortchanges the patient and contributes to decreased quality of care (and increases medical errors). In light of this, at the discretion of the treating therapist, **patients arriving more than 10 minutes late may be asked to reschedule for another day or may be offered another appointment time the same day if there is one available. The late arrival to the appointment will be considered a no-show, therefore the \$50.00 fee will apply and will have to be paid before the next appointment.**

**In addition, we reserve the right to terminate treatment after two no-shows, two late cancellations or three late arrivals.**

**I have read, understand and agree to this no-show, late cancelation and late arrival policy.**

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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 provided 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](http://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



# Men's Pelvic Pain Assessment

2763 E. Shaw Ave #102 (559)294-8112 (559)294-7805

[www.creativetherapeutics.com](http://www.creativetherapeutics.com)

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?
		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Currently taking
		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Currently taking
		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Currently taking
		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Currently taking
		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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):

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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 <b>DURING THE DAY</b> (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 <b>AT NIGHT</b> (to void or empty your bladder)?	0	1	2	3	4 or more
How many times do you go to the bathroom <b>DURING THE DAY (bowel movement)</b> ?	0	1-2	3-4	5-6	6+
How many times do you go to the bathroom <b>AT NIGHT (bowel movement)</b> ?	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	

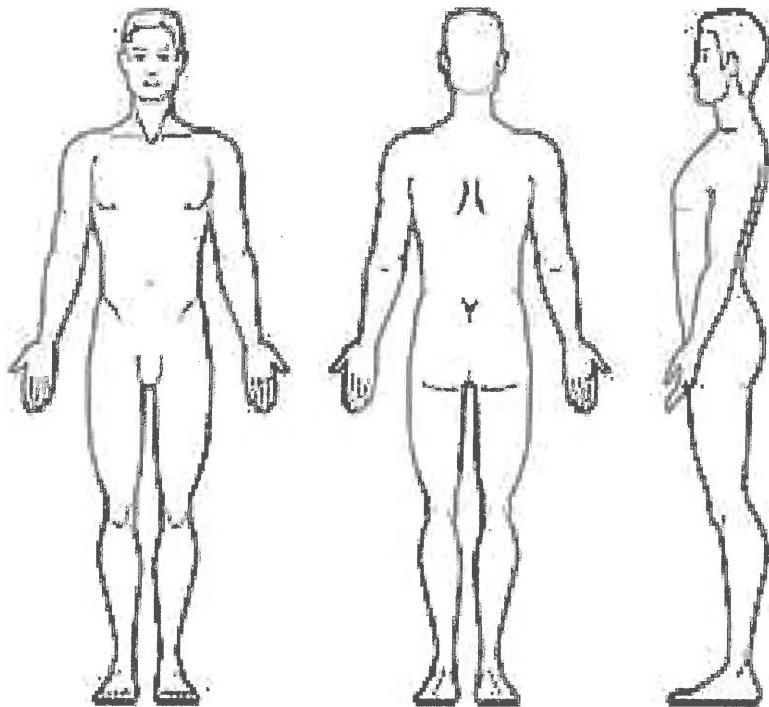


**Pain only**

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

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

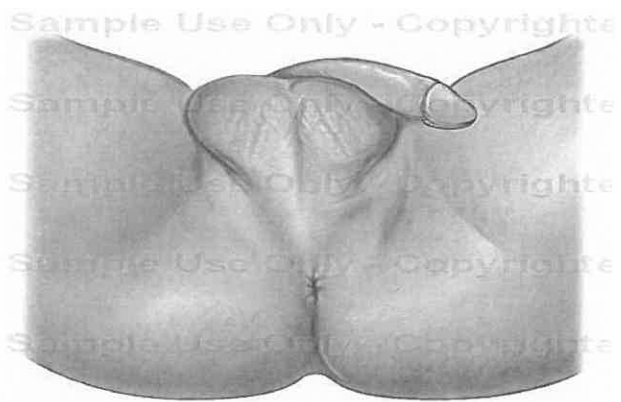
Left      Right

**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?

<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Homeopathic Medicine	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Anesthesiologist	<input type="checkbox"/> Lupron or Zoladex	<input type="checkbox"/> Psychotherapy
<input type="checkbox"/> Anti-seizure medication	<input type="checkbox"/> Massage	<input type="checkbox"/> Psychiatrist
<input type="checkbox"/> Antidepressants	<input type="checkbox"/> Meditation	<input type="checkbox"/> Rheumatologist
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Narcotics	<input type="checkbox"/> Skin Magnets
<input type="checkbox"/> Botox Injection	<input type="checkbox"/> Naturopathic	<input type="checkbox"/> Surgery
<input type="checkbox"/> Danazol (Danocrine)	<input type="checkbox"/> Nerve Blocks	<input type="checkbox"/> Tens unit
<input type="checkbox"/> Gastroenterologist	<input type="checkbox"/> Neurosurgeon	<input type="checkbox"/> Trigger point injections
<input type="checkbox"/> Family Practitioner	<input type="checkbox"/> Nonprescription Medicines	<input type="checkbox"/> Urologist
<input type="checkbox"/> Herbal Medicine	<input type="checkbox"/> Nutrition/Diet	<input type="checkbox"/> 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 \_\_\_\_\_