



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.

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 cancellation and late arrival policy.

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 case by case basis, 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



Continenence Questionnaire

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www.creativetherapeutics.com

Date: _____

Initial History and Physical Examination

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 times this current year and when? _____

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:

Year	Procedure	Surgeon	Findings

Medications

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

Medication/Dose	Provider	Did 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

Obstetrical History

How many pregnancies have you had? _____

Resulting in(#): _____ Full 9 Months _____ Premature _____ Miscarriage/Abortion _____ Living Children

Were there any complications during pregnancy, labor, delivery, or post-partum?

- Episiotomy C-Section Vacuum Post-partum hemorrhaging
 Vaginal Laceration Forceps Medication for bleeding Other _____

Medical History

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

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

Have you ever been hospitalized for anything other than child birth? Yes No

If yes, please explain _____

Have you had major accidents, such as a falls or a back injury? Yes NoHave you ever been treated for depression? Yes No Treatments: Medication Hospitalization Psychotherapy

Birth Control Method: Nothing Pill Vasectomy Vaginal Ring Depo Provera Condom
 IUD Hysterectomy Diaphragm Tubal Sterilization Other

Health HabitsHow 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: _____

Comments: _____

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

How many times do you go to the bathroom to void or empty your bladder during the day ?	3-6	7-10	11-14	15-19	20 or more
How many times do you go to the bathroom to void or empty your bladder at night ?	0	1	2	3	4 or more
How many times do you go to the bathroom for a bowel movement during the day ?	0	1-2	3-4	5-6	6+
How many times do you go to the bathroom for a bowel movement at night ?	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, labia, vagina, urethra, or perineum)?	Never	Occasionally	Usually	Always	
Do you have urgency after voiding?	Never	Occasionally	Usually	Always	
Do you have urgency after a bowel movement?	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	
Does your urgency bother you?	Never	Occasionally	Usually	Always	

Part 1: During the last 3 months did you leak urine or stool... (Check all that apply).

- When you were doing some physical activity, like coughing, sneezing, lifting, or exercising? Urine _____ Stool _____
- When you had the urge or feeling that you needed to empty your bladder or bowels
– but you couldn't get to the toilet fast enough? Urine _____ Stool _____
- Without physical activity and without a sense of urgency? Urine _____ Stool _____
- About equally as often with physical activity as with a sense of urgency? Urine _____ Stool _____

Part 2: How much has urine/stool leakage affected your ...

...ability to do household chores (cooking, housecleaning, laundry)?

Not at all slightly moderately greatly

...physical recreation such as walking, swimming, or other exercise?

Not at all slightly moderately greatly

...entertainment activities (movies, concerts, etc.)?

Not at all slightly moderately greatly

...ability to travel by car or bus more than 30 minutes from home?

Not at all slightly moderately greatly

...participation in social activities outside your home?

Not at all slightly moderately greatly

...emotional health (nervousness, depression, etc.)?

Not at all slightly moderately greatly

Does leakage have you feeling frustrated?

Not at all slightly moderately greatly

If you use pads or undergarments, how many times do you change in 24 hours? _____

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 vaginal/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 _____