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

Sandra Bausman, PT, WCS

Jessica M. Delgado, PT, DPT

Nancy Larson, PT, WCS

Kimberley K. Voelz, PT, DPT

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 cancelation 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 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

CREATIVE THERAPEUTICS
PHYSICAL THERAPY

## Medical History

The purpose of this questionnaire is to help us understand your health status. This form is considered part of your medical record.

**Patient Name:** ______________________ **Date of Birth:** ______________

**Referring Physician:** ______________________ **Primary Physician:** ______________

**Last date of general checkup** ____/_____/_____

**Primary Diagnosis:** ______________________ **Secondary:** ______________

**Occupation:** ______________________ **Hours worked per week:** _______

**If applicable, last date worked due to injury or condition:** ____/____/_____ **Date returned to work:** ___/____/_____

1. **Allergy History(medications, food, latex, etc….)/ Drug sensitivity:**______________________
2. **Surgeries:**______________________
3. **Recent Hospitalization Date:**___/___/___
   **Reason:**______________________
4. **List any prescription or non-prescription medications you are currently taking:**
   ☐ Non-steroidal ☐Anti-inflammations ☐ Muscle Relaxer ☐ Pain Medication
   ☐Other:______________________
   ______________________
5. **Have you had any of the following medical or rehabilitative care for this condition?**

| | NO | Yes (when) |
|---|---|---|
| Chiropractor | | |
| General Practitioner | | |
| Orthopedist | | |
| Podiatrist | | |
| Massage Therapy | | |
| Urologist | | |
| Physical Therapy | | |

| | No | Yes (when) |
|---|---|---|
| Occupational Therapy | | |
| Ct Scan/ Bone Scan | | |
| EMG or Nerve Test | | |
| MRI | | |
| X-Ray | | |
| Ultrasound | | |
| Bone Density | | |

6. **Have you had any of the following conditions or symptoms?**

| | NO | YES (Onset) |
|---|---|---|
| Asthma/Bronchitis/Emphysema | | |
| Chest pain/Shortness of Breath | | |
| Heart Disease/Angina | | |
| Pacemaker | | |
| High/Low Blood Pressure | | |
| Heart Attack/Heart Surgery | | |
| Blood Clot/Emboli | | |
| Stroke/TIA | | |
| Parkinson's Disease | | |
| Pins or Metal Implants | | Where: |
| Joint Replacement | | Where: |
| Diabetes | | 1 or 2: |
| Infectious Diseases | | |
| Cancer/Radiation | | Where: |
| Arthritis | | Where: |
| Osteoporosis | | |
| Hernia | | |

| | NO | YES (Onset) |
|---|---|---|
| Epilepsy/Seizures | | |
| Thyroid Condition | | |
| Multiple Sclerosis | | |
| Severe/Frequent Headaches | | |
| Vision/Hearing Difficulty | | |
| Numbness or Tingling | | |
| Sleeping Problems | | |
| Dizziness | | |
| Weakness/Energy Loss | | |
| Recent Weight Gain/Loss | | |
| Bowel/Bladder problems | | |
| Neck Injury/Surgery | | |
| Elbow/Hand- Injury/Surgery | | |
| Hip/Knee- Injury/Surgery | | |
| Ankle/Foot- Injury/Surgery | | |
| Shoulder Injury/Surgery | | |

7. **For Women Only:**

| | NO | Yes(when) |
|---|---|---|
| Pelvic inflammatory Disease | | |
| Complicated Pregnancies/Deliveries | | |
| Endometriosis | | |
| Are you pregnant? | | |

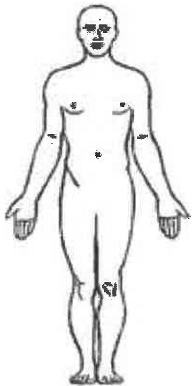
**Current complaints/what brought you to Physical Therapy?**

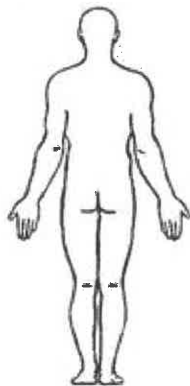
1. ______________________________ **How long?** ____________
2. ______________________________ **How long?** ____________
3. ______________________________ **How long?** ____________

**My symptoms are currently:**

☐ Getting Better ☐ Getting Worse ☐ Staying the same

**Do you expect to return to the activity levels were at prior to developing these symptoms?** Yes No





**List 3 postures or activities that make your symptoms worse**

1. ______________________________
2. ______________________________
3. ______________________________

**List 3 postures or activities that make your symptoms better**

1. ______________________________
2. ______________________________
3. ______________________________

**My symptoms:**

☐ Come and go ☐ Are Constant ☐ Are constant but change with activity

**How are you able to sleep at night due to your symptoms?**

☐ No problem sleeping ☐ Difficulty falling asleep ☐ Awakened by pain ☐ Sleep only with medication

**When are your symptoms the worst?**

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After Exercise

**When are your symptoms the best?**

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After Exercise

*Using a 0 to 10 scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describes:*

**Your current level of pain while completing this survey:** 1 2 3 4 5 6 7 8 9 10

**The best your pain has been during the past 24 hours:** 1 2 3 4 5 6 7 8 9 10

**The worst your pain has been during the past 24 hours:** 1 2 3 4 5 6 7 8 9 10

**Patient/Guardians Signature:** ______________________________ **Date:** ___/___/____

# *Quick*DASH

**Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.**

| | NO DIFFICULTY | MILD DIFFICULTY | MODERATE DIFFICULTY | SEVERE DIFFICULTY | UNABLE |
|---|---|---|---|---|---|
| 1. Open a tight or new jar. | 1 | 2 | 3 | 4 | 5 |
| 2. Do heavy household chores (e.g., wash walls, floors). | 1 | 2 | 3 | 4 | 5 |
| 3. Carry a shopping bag or briefcase. | 1 | 2 | 3 | 4 | 5 |
| 4. Wash your back. | 1 | 2 | 3 | 4 | 5 |
| 5. Use a knife to cut food. | 1 | 2 | 3 | 4 | 5 |
| 6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.). | 1 | 2 | 3 | 4 | 5 |

| | NOT AT ALL | SLIGHTLY | MODERATELY | QUITE A BIT | EXTREMELY |
|---|---|---|---|---|---|
| 7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? | 1 | 2 | 3 | 4 | 5 |

| | NOT LIMITED AT ALL | SLIGHTLY LIMITED | MODERATELY LIMITED | VERY LIMITED | UNABLE |
|---|---|---|---|---|---|
| 8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? | 1 | 2 | 3 | 4 | 5 |

| **Please rate the severity of the following symptoms in the last week.** *(circle number)* | NONE | MILD | MODERATE | SEVERE | EXTREME |
|---|---|---|---|---|---|
| 9. Arm, shoulder or hand pain. | 1 | 2 | 3 | 4 | 5 |
| 10. Tingling (pins and needles) in your arm, shoulder or hand. | 1 | 2 | 3 | 4 | 5 |

| | NO DIFFICULTY | MILD DIFFICULTY | MODERATE DIFFICULTY | SEVERE DIFFICULTY | SO MUCH DIFFICULTY THAT I CAN'T SLEEP |
|---|---|---|---|---|---|
| 11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)* | 1 | 2 | 3 | 4 | 5 |

***Quick*DASH DISABILITY/SYMPTOM SCORE** = $\left(\left[\frac{\text{sum of n responses}}{n}\right] - 1\right) \times 25$, where n is equal to the number of completed responses.

**A *Quick*DASH score may <u>not</u> be calculated if there is greater than 1 missing item.**

**PATIENT INFORMATION**

PATIENT NAME: ______________________________ DATE: ______________

ADDRESS: ______________________________ CITY: ____________ ZIP: ________

D.O.B.: ______________________________ SEX: MALE____ FEMALE___

HOME PHONE: ____________________ CELL: ______________________

WORK PHONE: ____________________ E-MAIL: ______________________

REFERRING PHYSICIAN: ______________________________________

PRIMARY INSURANCE: ______________________________________

INSURED'S NAME AND D.O.B.: ______________________________

SECONDARY INSURANCE: ______________________________________

****PLEASE PROVIDE RECEPTIONIST WITH YOUR ID AND INSURANCE CARD(S)****

Have you had physical therapy this year? Yes_____ No_____

If YES, How many times this current year and when? _____________