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

Sandra Bausman, PT, WCS
Nancy Larson, PT, WCS

Board Certified Women's Health Clinical Specialists

Etta L. Reynolds, PT

Orthopedic Manual Therapist

Veronica Maddox, PT, DPT

Welcome to Creative Therapeutics Physical Therapy. Your appointment is scheduled for:____.
Please arrive 10 minutes before your appointment time.

At your appointment please bring: The packet completed, your Referral if it was not faxed to this office, your health insurance information (card (s) and your current ID (driver's license).

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 and in order for your visits to be processed through your health insurance.

2. If you are being treated at another Clinic for physical therapy, please arrange these appointments on different days you have your appointment here. It can affect how your insurance plan may or may not pay of you have TWO physical therapy sessions on the same day.

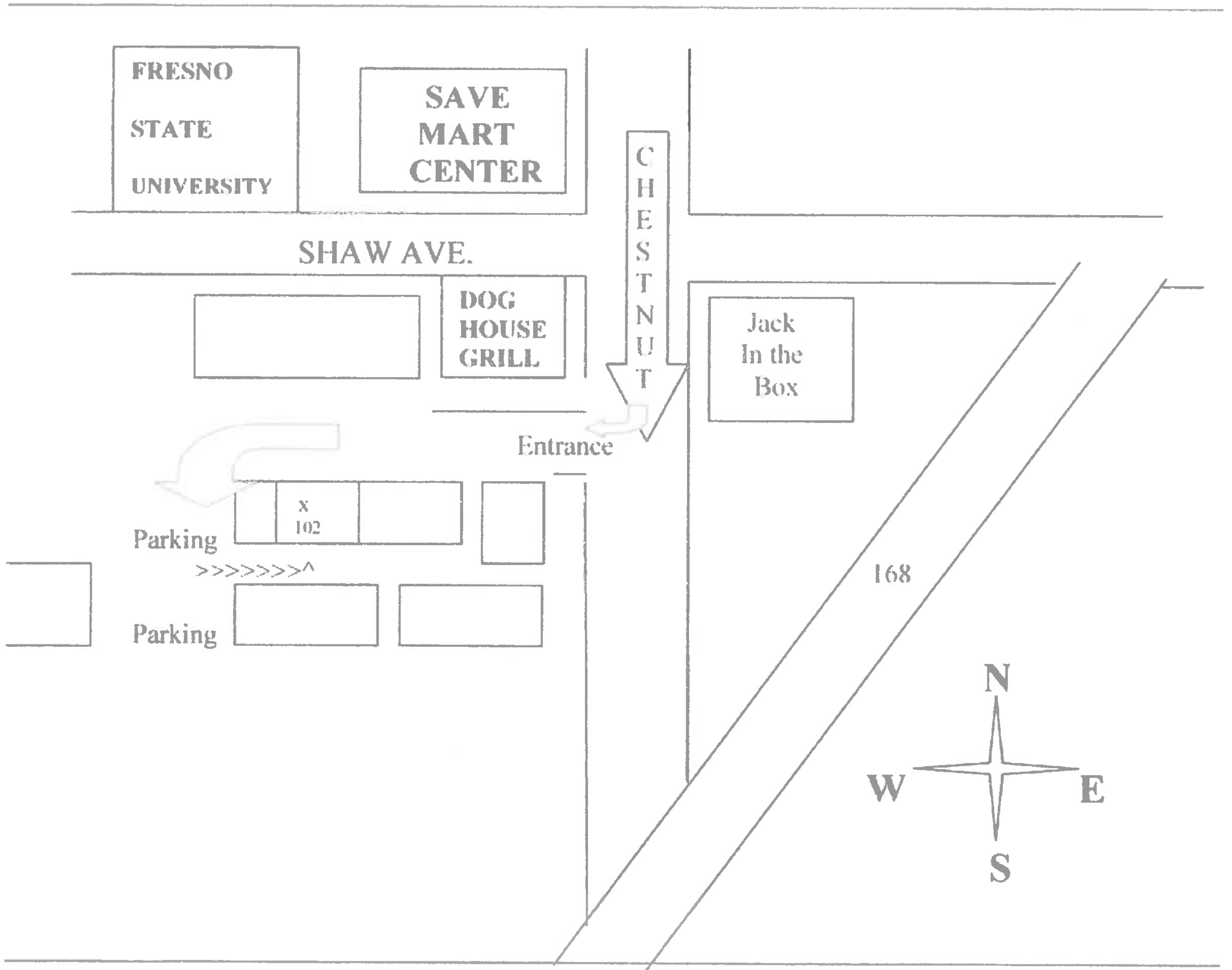
As a courtesy to others with *allergy sensitivities*, we kindly ask you to please refrain from wearing colognes or perfumes during your visit here.

A fee of $75.00 will be charged for failure to cancel an INITIAL FIRST VISIT appointment without a 24 hour prior 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

MAP ON REVERSE SIDE



CREATIVE THERAPEUTICS PHYSICAL THERAPY
2763 E. SHAW AVE. #102
FRESNO, CA. 93710

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 ealth 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?		

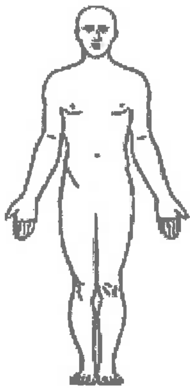
Current complaints/what brought you to Physical Therapy?

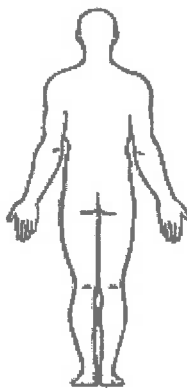
1. ______________________________ **How long?** __________
2. ______________________________ **How long?** __________
3. ______________________________ **How long?** __________

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:** ___/___/___

PATIENT INFORMATION

PATIENT NAME:______________________________________ DATE:________________

ADDRESS:________________________________ CITY:______________ ZIP:_________

BIRTHDATE:____ SEX: MALE____ FEMALE___

HOME PHONE:________________________ CELL:____________________________

WORK PHONE:_______________________ E-MAIL:____________________________

REFERRING PHYSICIAN:____

PRIMARY INSURANCE:____

INSURED'S NAME AND BIRTHDATE:_____________________________________

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? _________