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

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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

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? | | |

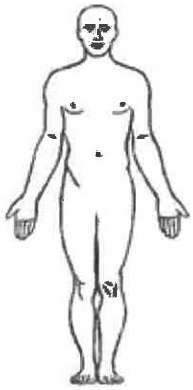
**Current complaints/what brought you to Physical Therapy?**

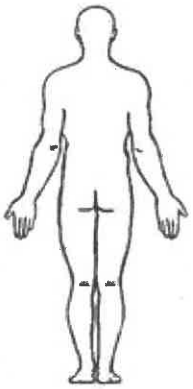
1. _____ **How long?** _____
2. _____ **How long?** _____
3. _____ **How long?** _____

**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:*

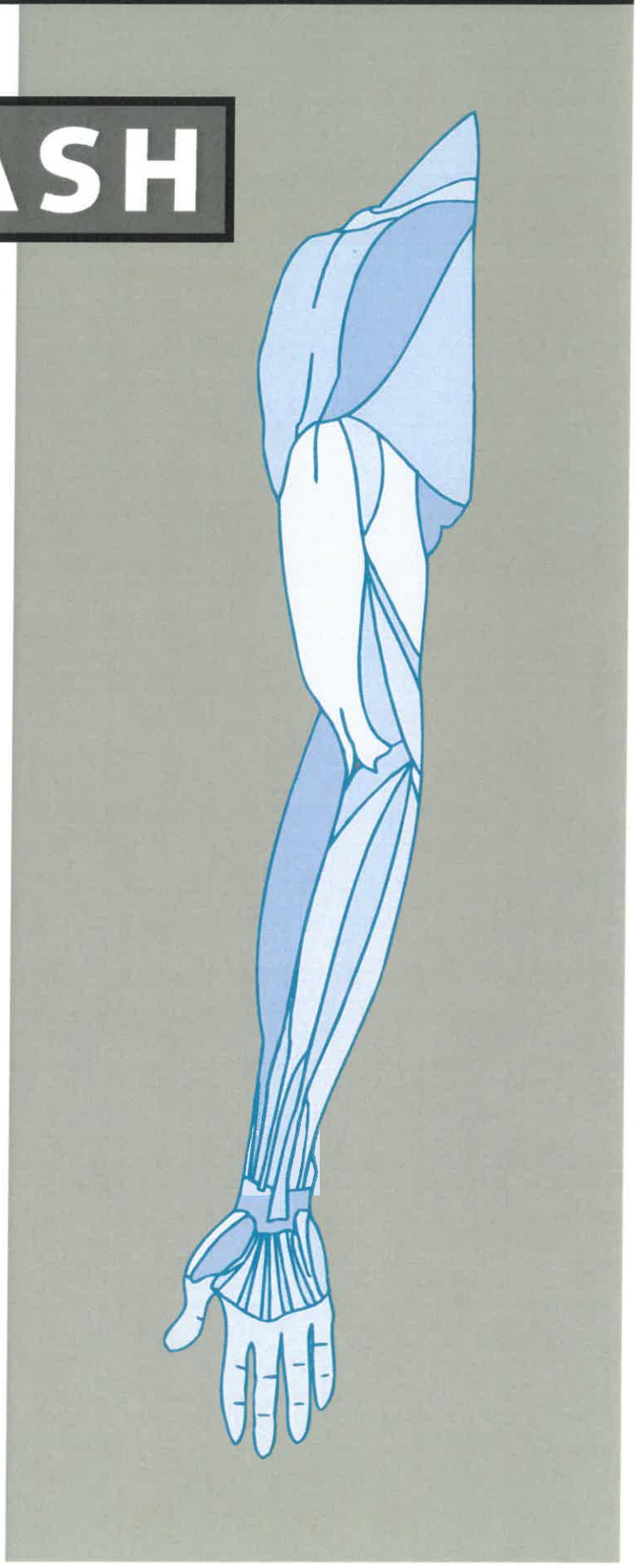
**Your current level of pain while completing this survey:** 1 2 3 4 5 6 7 8 9 10

**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:** ___/___/___

# THE DASH



## INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

# DISABILITIES OF THE ARM, SHOULDER AND HAND

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. Write. | 1 | 2 | 3 | 4 | 5 |
| 3. Turn a key. | 1 | 2 | 3 | 4 | 5 |
| 4. Prepare a meal. | 1 | 2 | 3 | 4 | 5 |
| 5. Push open a heavy door. | 1 | 2 | 3 | 4 | 5 |
| 6. Place an object on a shelf above your head. | 1 | 2 | 3 | 4 | 5 |
| 7. Do heavy household chores (e.g., wash walls, wash floors). | 1 | 2 | 3 | 4 | 5 |
| 8. Garden or do yard work. | 1 | 2 | 3 | 4 | 5 |
| 9. Make a bed. | 1 | 2 | 3 | 4 | 5 |
| 10. Carry a shopping bag or briefcase. | 1 | 2 | 3 | 4 | 5 |
| 11. Carry a heavy object (over 10 lbs). | 1 | 2 | 3 | 4 | 5 |
| 12. Change a lightbulb overhead. | 1 | 2 | 3 | 4 | 5 |
| 13. Wash or blow dry your hair. | 1 | 2 | 3 | 4 | 5 |
| 14. Wash your back. | 1 | 2 | 3 | 4 | 5 |
| 15. Put on a pullover sweater. | 1 | 2 | 3 | 4 | 5 |
| 16. Use a knife to cut food. | 1 | 2 | 3 | 4 | 5 |
| 17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.). | 1 | 2 | 3 | 4 | 5 |
| 18. 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 |
| 19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.). | 1 | 2 | 3 | 4 | 5 |
| 20. Manage transportation needs (getting from one place to another). | 1 | 2 | 3 | 4 | 5 |
| 21. Sexual activities. | 1 | 2 | 3 | 4 | 5 |

# DISABILITIES OF THE ARM, SHOULDER AND HAND

| | NOT AT ALL | SLIGHTLY | MODERATELY | QUITE A BIT | EXTREMELY |
|---|---|---|---|---|---|
| 22. 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? *(circle number)* | 1 | 2 | 3 | 4 | 5 |

| | NOT LIMITED AT ALL | SLIGHTLY LIMITED | MODERATELY LIMITED | VERY LIMITED | UNABLE |
|---|---|---|---|---|---|
| 23. 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? *(circle number)* | 1 | 2 | 3 | 4 | 5 |

Please rate the severity of the following symptoms in the last week. *(circle number)*

| | NONE | MILD | MODERATE | SEVERE | EXTREME |
|---|---|---|---|---|---|
| 24. Arm, shoulder or hand pain. | 1 | 2 | 3 | 4 | 5 |
| 25. Arm, shoulder or hand pain when you performed any specific activity. | 1 | 2 | 3 | 4 | 5 |
| 26. Tingling (pins and needles) in your arm, shoulder or hand. | 1 | 2 | 3 | 4 | 5 |
| 27. Weakness in your arm, shoulder or hand. | 1 | 2 | 3 | 4 | 5 |
| 28. Stiffness 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 |
|---|---|---|---|---|---|
| 29. 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 |

| | STRONGLY DISAGREE | DISAGREE | NEITHER AGREE NOR DISAGREE | AGREE | STRONGLY AGREE |
|---|---|---|---|---|---|
| 30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)* | 1 | 2 | 3 | 4 | 5 |

**DASH DISABILITY/SYMPTOM SCORE** = _____ ( [(sum of n responses / n) - 1] x 25, where n is the number of completed responses.)

**A DASH score may <u>not</u> be calculated if there are greater than 3 missing items.**


## 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? _____