CREATIVE THERAPEUTICS
PHYSICAL THERAPY

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

Sandra Bausman, PT, WCS

Nancy Larson, PT, WCS

Welcome to Creative Therapeutics Physical Therapy. Your appointment has been scheduled on: _____
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

MAP ON REVERSE SIDE

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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 _____

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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 _____

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

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

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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?		

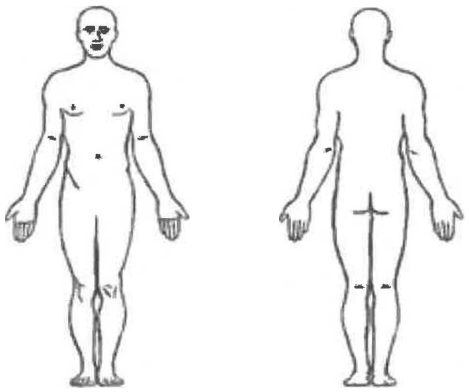
Current complaints/what brought you to Physical Therapy?

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 NAME: _____ **ID#:** _____ **DATE:** _____

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

NECK DISABILITY INDEX – INITIAL VISIT

1. Pain Intensity
(0) I have no pain at the moment.
(1) The pain is very mild at the moment.
(2) The pain is moderate at the moment.
(3) The pain is fairly severe at the moment.
(4) The pain is very severe at the moment.
(5) The pain is the worse imaginable at the moment.

2. Personal Care (washing, dressing, etc)
(0) I can look after myself normally without extra pain.
(1) I can look after myself normally but it causes extra pain.
(2) It is painful to look after myself and I am slow and careful.
(3) I need some help but manage most of my personal care.
(4) I need help every day in most aspects of self care.
(5) I cannot get dressed, wash with difficulty and stay in bed

3. Lifting
(0) I can lift heavy weights without extra pain.
(1) I can lift heavy weights but it gives me extra pain.
(2) Pain prevents me from lifting heavy weights off the floor but I can manage if they are on a table.
(3) Pain prevents me from lifting heavy weights but I can manage if they are conveniently placed.
(4) I can lift only very light weights.
(5) I cannot lift or carry anything at all.

4. Headache
(0) I have no headaches at all.
(1) I have slight headaches which come infrequently.
(2) I have moderate headaches which come infrequently.
(3) I have moderate headaches which come frequently.
(4) I have severe headaches which come infrequently.
(5) I have headaches almost all the time.

5. Recreation
(0) I am able engage in all my recreational activities without pain.
(1) I am able to engage in my recreational activities with some pain.
(2) I am able to engage in most but not all of my usual recreational activities because of my neck pain.
(3) I am able to engage in a few of my usual recreational activities with some neck pain.
(4) I can hardly do any recreational activities because of neck pain.
(5) I can't do any recreational activities at all.

6. Reading
(0) I can read as much as I want with no pain in my neck.
(1) I can read as much as I want with slight neck pain.
(2) I can read as much as I want with moderate neck pain.
(3) I can't read as much as I want because of moderate neck pain.
(4) I can hardly read at all because of severe neck pain.
(5) I cannot read at all because of neck pain.

7. Work
(0) I can do as much as I want to.
(1) I can only do my usual work but no more.
(2) I can do most of my usual work but no more.
(3) I cannot do my usual work.
(4) I can hardly do any usual work at all.
(5) I can't do any work at all.

8. Sleeping
(0) Pain does not prevent me from sleeping well.
(1) My sleep is slightly disturbed (<1 hr sleep loss).
(2) My sleep is mildly disturbed (1-2 hr sleep loss).
(3) My sleep is moderately disturbed (2-3 hr sleep loss).
(4) My sleep is greatly disturbed (3-4 hr sleep loss).
(5) My sleep is completely disturbed (5-7 hr sleep loss).

9. Concentration
(0) I can concentrate fully when I want with no difficulty.
(1) I can concentrate fully when I want with slight difficulty.
(2) I have a fair degree of difficulty concentrating when I want.
(3) I have a lot of difficulty concentrating when I want.
(4) I have great difficulty concentrating when I want.
(5) I cannot concentrate at all.

10. Driving
(0) I can drive my car without neck pain.
(1) I can drive my car as long as I want with slight neck pain.
(2) I can drive my car as long as I want with moderate neck pain.
(3) I can't drive my car as long as I want because of moderate pain.
(4) I can hardly drive my car at all because of severe neck pain.
(5) I can't drive my car at all.

Therapist Use Only

Comorbidities:
☐Cancer
☐Diabetes
☐Heart Condition
☐High Blood Pressure
☐Multiple Treatment Areas
☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
☐Obesity
☐Surgery for this Problem
☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD9 Code: _____

PATIENT INFORMATION

PATIENT NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

D.O.B.: _____ SEX: MALE FEMALE

HOME PHONE: _____ CELL: _____

WORK PHONE: _____ E-MAIL: _____

EMERGENCY CONTACT: _____ PHONE: _____

RELATION TO PATIENT: _____

REFERRING PHYSICIAN: _____

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? _____

MAIN ENTRANCE
2763 E. Shaw Ave Suite 102