Creative Therapeutics Physical Therapy, Inc.
2763 E Shaw, Suite 102
Fresno, Ca 93710
Phone: (559) 294-8112
Fax: (559) 294-7805

Sandra Bausman, PT, WCS
Nancy Morrison, PT, WCS
Etta L. Reynolds, PT

Welcome to Creative Therapeutics Physical Therapy.
Please take a moment and fill out the information packet included with this letter.

Please bring the packet with you, your insurance information, along with your prescription or referral to your scheduled appointment.

For your convenience, we have provided you with a map to our facility.

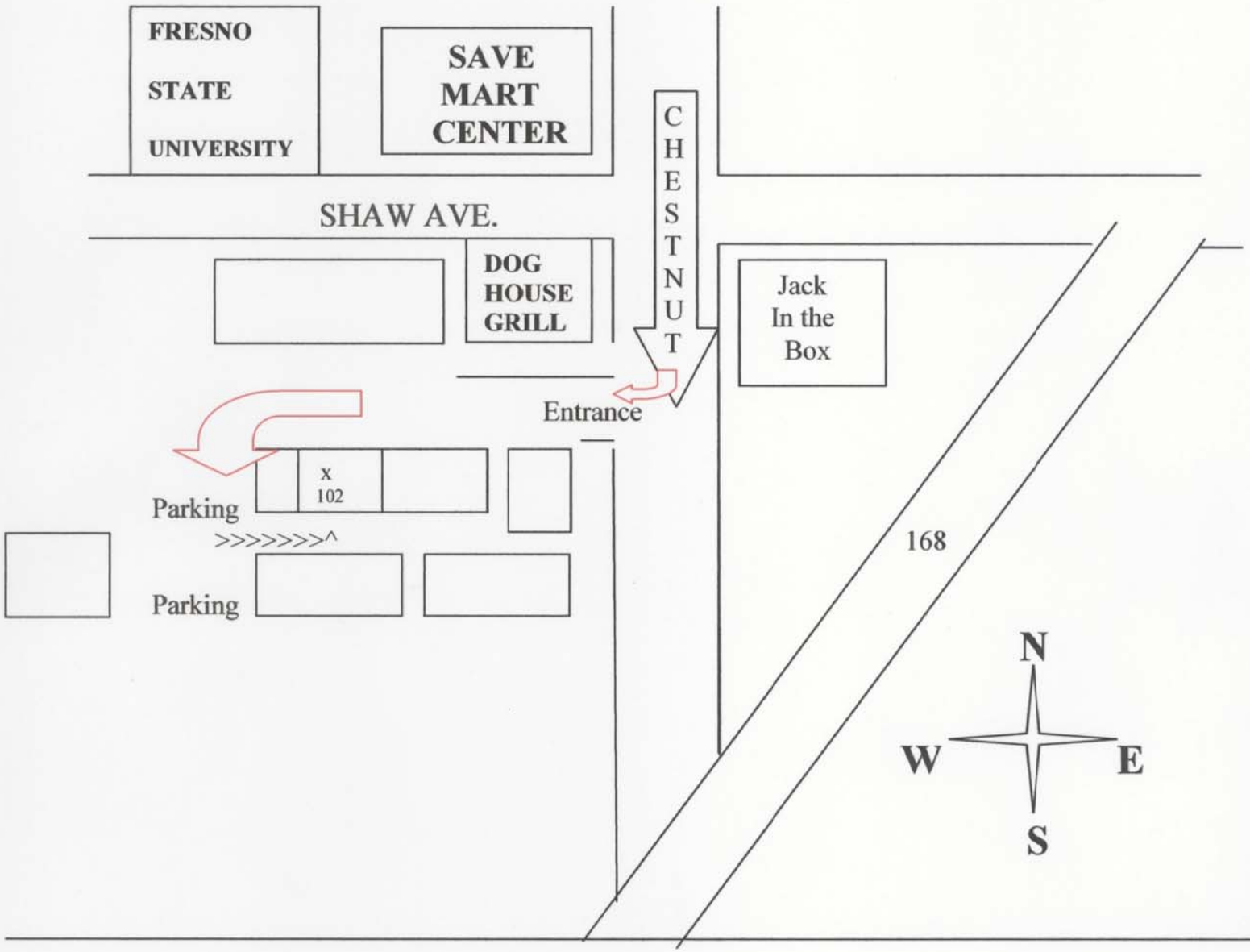
Please note: We will need a prescription from your *medical doctor* in order for your visits to be processed through your insurance. If this is not the case, please contact our office with this information so that we may reschedule your appointment at a later time that will not cause any insurance discrepancies.

Your medical insurance will not accept a prescription from your general dentist, (Exception: Oral surgeons) and your primary care physician will need to support your dentists' recommendations.

Also, as a courtesy to others with allergic sensitivities we ask that you refrain from wearing colognes and perfumes. Thank you.

If you have any questions, please feel free to call our office.

Sincerely,
Creative Therapeutics Physical Therapy



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

CONSENT FORM FOR INTERNAL PELVIC MUSCLE EVALUATION AND TREATMENT

I, _____ give my consent for Sandra Bausman or Nancy Morrison, Physical Therapist, 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 present in the room during the procedure and _____ choose _____ refuse this option.

_____
Patient's Signature

5. I have read this consent form and understand its terms, and I am signing it knowingly and voluntarily.

Patient Signature:_____Date:_____

Witness Signature:_____Date:_____

FINANCIAL POLICY

Communication with our clients regarding our financial policy assists us in providing the best service to you. Please read the following. Your signature is required at the bottom of the page. Thank you

Private Pay-(clients without insurance) Full payment is required when services are rendered to continue treatment.

Insurance Company Reimbursement-Clients are required to contact their insurance company to verify their deductible status and the amount of coverage for physical therapy available to them. We will also be contacting your insurance company to verify your coverage. **It is important to remember that what the insurance company tells us is not a GUARANTEE of payment from them.**

Deductible and Co-payment- If you have not previously met your deductible, a payment of **$25.00** per visit will be due at time of service.

Your insurance company will be billed and you will receive a statement for the remaining balance. Co-payments are due at time of service.

Any charges that your insurance company does not pay for or denies will be the patient's responsibility.

Purchasing products-Payment for all products are the patient's responsibility and due at time of purchase.

Workers Compensation-All pre-authorized bills will be sent directly to your Worker's Compensation carrier.

Auto Accident- You must supply us with **your** insurance company information and contact person. If your insurance company does not pay in a timely manner, or are waiting until the accident is completely settled to make payment-**you** will be 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 detailed above. **I understand that I I am responsible for all charges regardless of my existing medical coverage**.

A fee of $25.00 will be charged for cancellation of my appointment without 4 hours prior notice or failure to attend a scheduled appointment.

Consent for Treatment/Release of Insurance Assignment Medical Information.

YES___NO___I authorize any and all 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.

YES___NO___I hereby authorize Creative Therapeutics P.T., Inc. to release to my insurance company, health plan, or insurance group, any medical records or information concerning the treatment to obtain reimbursement on my behalf for the treatment or service provided by Creative Therapeutics 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 in not conditioned on my agreement to disclose information to the parties. If I revoke my consent, I will be responsible for paying for all services rendered by Creative Therapeutics P.T., Inc.

I have read, understand and agree to this financial agreement SIGNATURE:

_____**DATE:** _____

CREATIVE THERAPEUTICS P.T., INC

HEALTH INFORMATION PORTABILTIY AND PRACTICE ACT

HIPPA

I have read and fully understand CREATIVE THERAPEUTICS, P.T., INC., Notice of Information Practices. I understand that CREATIVE THERAPEUTICS P.T., INC. may use or disclose my personal health information for the purposes of carrying out treatment obtaining payment, evaluating the quality of service 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 operation if I notify the practice. I also understand that CREATIVE THERAPEUCTICS P.T., INC will consider requests for restriction 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 P.T., 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.

_____

Patient Name

_____

Patients Signature

_____

Date

PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Myocardial Infarction	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐

MUSCLE CONDITION	YES	NO
Carpal Tunnel R/L	☐	☐
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity	☐	☐
Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐

Other: _____

_____

_____

_____

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day ____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week ____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week ____
☐ 5+ x Week	☐ Heavy Labor			

What types of exercise do you perform? : _____

What things cause stress in your life? :

Are you taking any seizure medication? ☐YES ☐NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐YES ☐NO If yes list name: _____

List all medications you are currently taking: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? ☐ YES ☐ NO What week?: _____

Have you had any injuries related to work? ☐ YES ☐ NO If yes list body part and date.: _____

Have you had any Auto Accidents ☐ YES ☐ NO If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? ☐ YES ☐ NO Where:

_____ _____

Signature of Patient, Parent, Guardian, Personal Representative Date

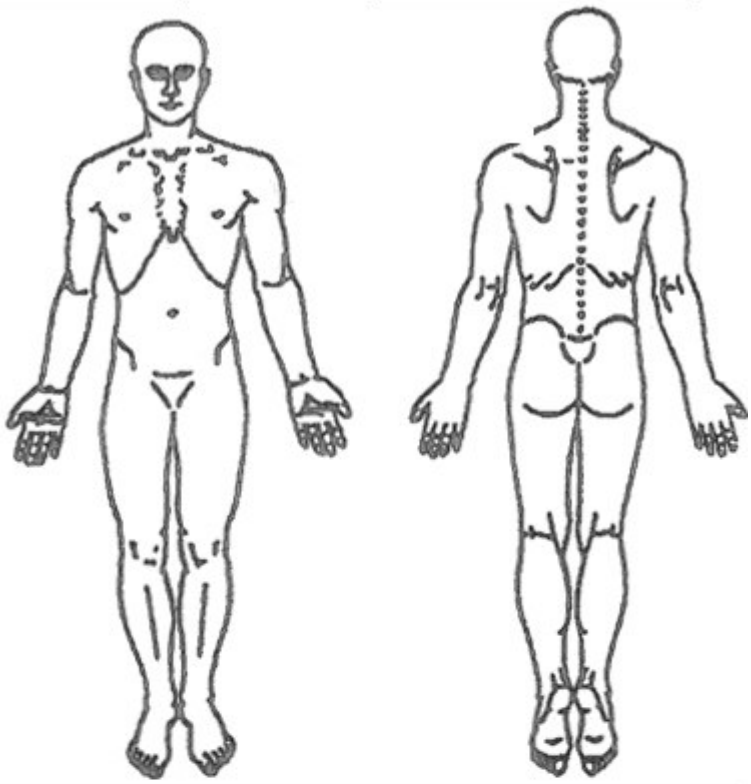
Pain and Symptom Status Report

Name: _____ **Date:** _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing

Ache	Burning	Numbness
MMM	— — —	O O O O
M	— —	O O O

Pins and Needles	Stabbing	Other
o o o o o o o o o	/ / / / / /	x x x x
o o o o o o o o	/ / / /	x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of your problem occurred on. _____

2nd Complaint _____

3rd Complaint: _____

Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:

No Pain **0 1 2 3 4 5 6 7 8 9 10** **Pain as bad as it gets.**

Please circle on the scale below to indicate your <u>AVERAGE</u> level of pain:

No Pain **0 1 2 3 4 5 6 7 8 9 10** **Pain as bad as it gets.**

Please circle on the scale below to indicate your <u>WORST</u> level of pain:

No Pain **0 1 2 3 4 5 6 7 8 9 10** **Pain as bad as it gets.**

Additional Comments _____

CREATIVE THERAPEUTICS PHYSICAL THERAPY

PHONE#: 559-294-8112 2763 E. SHAW, #102 FRESNO, CA 93710 FAX# 559-294-7805

PATIENT INFORMATION

PATIENT NAME: _____ DATE:_____

BIRTHDATE:_____SEX: MALE_____FEMALE_____

ADDRESS:_____CITY:_____STATE:_____ZIP_____

E-MAIL:_____

HOME PHONE:_____WORK:_____CELL:_____

EMPLOYER:_____SOCIAL SECURITY#_____

SPOUSE'S NAME: _____EMERGENCY PHONE#_____

REFERRING PHYSICIAN: _____DATE OF INJURY/ILLNESS:_____

PHYSICIANS ADDRESS:_____PHONE#_____

PRIMARY INSURANCE CO.NAME:_____

ADDRESS_____CITY_____STATE_____ZIP_____

NAME OF INSURED:_____INSUREDS ID#_____

INSURANCE PHONE#_____ EXT:_____

SECONDARY INSURANCE NAME:_____

ADDRESS:_____CITY_____ZIP_____

INSURANCE PHONE#_____EXT_____

NAME OF INSURED_____INSUREDS ID:_____

******PLEASE PROVIDE RECEPTIONIST WITH COPY OF INSURANCE CARDS******

WAS THIS AN AUTO ACCIDENT: YES/NO IF YES, WE MUST HAVE **YOUR** AUTO INS. INFORMATION.

IS THIS WORK RELATED:YES/NO IF YES: CLAIM# _____CLAIMS ADJUSTER_____

HAVE YOU BEEN SEEN FOR ANY OTHER PHYSICAL THERAPY ELSEWHERE? YES/NO

IF SO, HOW MANY TIMES THIS YEAR?_____