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 and any administrative operations related to treatment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment 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 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 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; 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:

Jen Adams, Office Administrator
2763 E. Shaw Ave., #107 Fresno, CA 93710
Telephone: 559-294-8112 FAX: 559-294-7805

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 for the full initial evaluation fee of $175.00. Follow-up visits not cancelled 4 hours prior will be subject to a late cancellation fee of $75.00.**

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 $75.00 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 cancellations or three late arrivals.

I have read, understand and agree to this no-show, late cancellation and late arrival policy.

SIGNATURE **DATE**

WELCOME TO CREATIVE THERAPEUTICS PHYSICAL THERAPY

2763 E. SHAW AVE. STE #107, FRESNO CA 93710 (559) 294-8112
www.creativetherapeutics.com

SANDRA BAUSMAN, PT **NANCY LARSON, PT**

Creative Therapeutics Physical Therapy is a small private practice offering personalized PT services, please refer to our website to learn more about our services. We have private treatment rooms and assess each person's needs individually. Due to the nature of our services, we do not bill any insurances. Each patient is responsible to pay at the time of each visit.

The charges are:

Initial exam: $175.00 **Follow-up visit: $110.00**

Your appointment has been scheduled for _____.

Please arrive 10 minutes early for your first appointment if you have your intake forms filled out; please arrive 20 min early if you do not have your intake forms filled out. The intake forms can be found on our website.

CONSENT FOR TREATMENT/RELEASE OF MEDICAL INFORMATION:

PLEASE INITIAL BELOW:

_____ I authorize the therapy services that my provider feels necessary or advisable in conjunction with my referral.

_____ I am aware that CTPT will not be billing my insurance company for my services received. I may request a super bill from Creative Therapeutics Physical Therapy (559)294-8112 at the end of each month or at the conclusion of 4 of my services.

We prefer to have a referral from your doctor or dentist to help us understand the nature of your specific diagnosis. We will make exceptions based on the history and symptoms that are present, these decisions are made at the discretion of your therapist. California is a direct access state, allowing us to treat for a limited number of visits without a referral.

_____

Signature Date

Health Assessment

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

Patient Information

Name: _____DOB: _____Sex: Male_____ Female_____

Address: _____City: _____Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Employer: _____

Emergency Contact: _____ Relation to Patient: _____

Emergency Contact Phone: _____

Have you had any of the following medical or rehabilitative care for this condition?

	No	**Yes** (when)
Chiropractor		
General Practitioner		
Orthopedist		
Podiatrist		
Massage Therapist		
Physical Therapy		

	No	**Yes** (when)
Occupational Therapy		
CT Scan/ Bone Scan		
EMG or Nerve Test		
MRI		
Ultrasound		
Bone Density Scan		

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		

1. **Surgeries:** _____
2. **Recent Hospitalization Date:** ___/___/____
   Reason: _____
3. **List any prescription or non-prescription medications you are currently taking:**
   - Non-steroidal
   - Anti-inflammations
   - Muscle Relaxer
   - Pain Medication
   - Other: _____

For Women Only:

	No	**Yes** (when)
Pelvic Inflammatory Disease		
Complicated Pregnancies/Deliveries		
Endometriosis		
Are you pregnant?		

Please list any prescriptions/supplements:

_____

_____

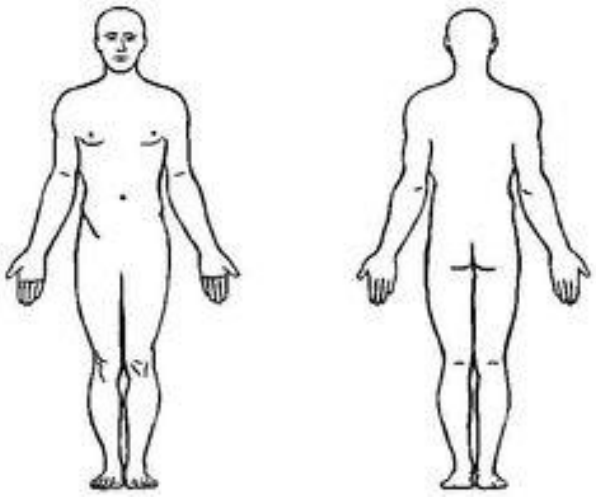
Current complaints/what brought you to Physical Therapy?

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

My symptoms are currently:

☐Getting Better ☐Getting Worse ☐The Same ☐Intermittent ☐Constant ☐Change with activity

Do you expect to return to your previous level of activity and function? 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 changes with activity

How are you able to sleep at night?

☐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 describe:

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: ___/___/_____

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.**

LEFS – INITIAL VISIT

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

Source: Binkley et al (1999): The Lower Extremity Functional Scale(LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383.

	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1. Any of your usual work, housework or school activities	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3. Getting into or out of the bath	0	1	2	3	4
4. Walking between rooms	0	1	2	3	4
5. Putting on your shoes or socks	0	1	2	3	4
6. Squatting	0	1	2	3	4
7. Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
8. Performing light activities around your home	0	1	2	3	4
9. Performing heavy activities around your home	0	1	2	3	4
10. Getting into or out of a car	0	1	2	3	4
11. Walking 2 blocks	0	1	2	3	4
12. Walking a mile	0	1	2	3	4
13. Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
14. Standing for 1 hour	0	1	2	3	4
15. Sitting for 1 hour	0	1	2	3	4
16. Running on even ground	0	1	2	3	4
17. Running on uneven ground	0	1	2	3	4
18. Making sharp turns while running fast	0	1	2	3	4
19. Hopping	0	1	2	3	4
20. Rolling over in bed	0	1	2	3	4

Therapist Use Only

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

ICD Code:

_____

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

MODIFIED OSWETRY DISABILITY SCALE – INITIAL VISIT

1. Pain Intensity

(0) I can tolerate the pain I have without having to use pain medication.
(1) The pain is bad, but I can manage without having to take pain medication.
(2) Pain medication provides me with complete relief from pain.
(3) Pain medication provides me with moderate relief from pain.
(4) Pain medication provides me with little relief from the pain.
(5) Pain medication has no effect on my pain.

2. Personal Care (washing, dressing, etc.)

(0) I can take care of myself normally without causing increased pain.
(1) I can take care of myself normally, but it increases my pain.
(2) It is painful to take care of myself, and I am slow and careful.
(3) I need help, but I am able to manage most of my personal care.
(4) I need help every day in most aspects of my care.
(5) I do not get dressed, wash with difficulty, and stay in bed.

3. Lifting

(0) I can lift heavy weights without increased pain.
(1) I can lift heavy weights, but it causes increased pain.
(2) Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g, on a table).
(3) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
(4) I can lift only very light weights.
(5) I cannot lift or carry anything at all.

4. Walking

(0) Pain does not prevent me from walking any distance.
(1) Pain prevents me from waling more than 1 mile.
(2) Pain prevents me from walking more than ½ mile.
(3) Pain prevents me from walking more than ¼ mile.
(4) I can only walk with crutches or a cane.
(5) I am in bed most of the time and have to crawl to the toilet.

5. Sitting

(0) I can sit in any chair as long as I like.
(1) I can only sit in my favorite chair as long as I like.
(2) Pain prevents me from sitting more than 1 hour.
(3) Pain prevents me from sitting more than ½ hour.
(4) Pain prevents me from sitting more than 10 minutes.
(5) Pain prevents me from sitting at all.

6. Standing

(0) I can stand as long as I want without increased pain.
(1) I can stand as long as I want but, it increases my pain.
(2) Pain prevents me from standing more than 1 hour.
(3) Pain prevents me from standing more than ½ hour.
(4) Pain prevents me from standing more than 10 minutes.
(5) Pain prevents me from standing at all.

7. Sleeping

(0) Pain does not prevent me from sleeping well.
(1) I can sleep well only by using pain medication.
(2) Even when I take pain medication, I sleep less than 6 hours.
(3) Even when I take pain medication, I sleep less than 4 hours.
(4) Even when I take pain medication, I sleep less than 2 hours.
(5) Pain prevents me from sleeping at all.

8. Social Life

(0) My social life is normal and does not increase my pain.
(1) My social life is normal, but it increases my level of pain.
(2) Pain prevents me from participating in more energetic activities (eg, sports, dancing).
(3) Pain prevents me from going out very often.
(4) Pain has restricted my social life to my home.
(5) I have hardly any social life because of my pain.

9. Traveling

(0) I can travel anywhere without increased pain.
(1) I can travel anywhere, but it increases my pain.
(2) My pain restricts my travel over 2 hours.
(3) My pain restricts my travel over 1 hour.
(4) My pain restricts my travel to short necessary journeys under ½ hour.
(5) My pain prevents all travel except for visits to the physician/therapist or hospital.

10. Employment / Homemaking

(0) My normal homemaking/job activities do not cause pain.
(1) My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
(2) I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg, lifting, vacuuming).
(3) Pain prevents me from doing anything but light duties.
(4) Pain prevents me from doing even light duties.
(5) Pain prevents me from performing any job or homemaking chores.

Therapist Use Only

Comorbidities: ☐ Cancer ☐ Neurological Disorders (e.g. Parkinson's, Muscular Dystrophy, Huntington;s, CVA, Alzheimer's, TBI)
☐ Diabetes ☐ Obesity
☐ Heart Condition ☐ Surgery for this problem
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ICD Code: _____