drcarr@erincarrpt.com
ph 323.304.1602 / fx 323.739.2737
Dr. Carr Integrative Physical Therapy

Patient Information

You can type in information, print, and handwrite initials/ signature. Or you may simply print and enter all information by hand.

Name _____ **DOB** _____ **Age** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____**Ce**ll _____

Work _____ **Email Address** _____

Occupation/Sport _____

Spouse/Guardian _____

(circle one) Name Phone Number

Emergency Contact _____
Name Phone Number

Primary Physician _____
Name Phone Number

Attorney Info (if applicable) _____

How did you hear about us?

_____

_____

Patient/Guardian Signature: _____

Printed Name: _____ **Date**: _____

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Patient/Responsible Party Name: _____

Financial Agreement and Consent to Treat

_____ **(Initial)** Dr. Carr Integrative Physical Therapy is a Medicare provider and a non contracted out of network provider for all other insurances for physical therapy services. I understand that Dr. Carr Integrative Physical Therapy I cannot guarantee my insurance company will pay for the services provided. I agree to pay all fees and charges for treatment (deductibles, copays, coinsurance, or the entire balance) if necessary.

_____ **(Initial)** If I choose not to use my out of network insurance benefits, the cash rate is due at the time of treatment. I also understand if I purchase a discounted package of sessions, it is to be paid upfront and in full on the first session. I understand I will be provided with a super bill and receipt after each treatment session if I want to submit it to my insurance company for potential reimbursement.

_____ **(Initial)** I consent to have Dr. Carr Integrative Physical Therapy to provide physical therapy services at Dr. Carr Integrative Physical Therapy's Office or in my home/office according to the diagnosis by my physician. I understand that this consent may be changed, adjusted or revoked by me at any time. I also authorize Dr. Carr Integrative Physical Therapy to release any information regarding my care that is necessary to have my claims paid.

Payment for Services

_____ **(initial)** Private pay, co-payment, co-insurance and/or deductible payments are required each treatment. It is my responsibility to make these payments in order for me to continue with my treatments. I understand that every attempt will be made by Dr. Carr Integrative Physical Therapy to collect the proper amount however I understand that I may receive an additional bill in the event that my insurance company does not process claims in the same manner as was quoted to Dr. Carr Integrative Physical Therapy. I also agree that anything an Dr. Carr Integrative Physical Therapy employee or representative says about my health insurance benefits is speculation and it is my responsibility to check what benefits are available for services.

Credit Card on File and Cancellation / No Show Policy

_____ **(initial)** It is required that all private cash pay patients, patients owing an insurance co-payment, co-insurance and/or deductible provide their credit card or debit card information and hereby authorize Dr. Carr Integrative Physical Therapy, Inc. to charge me only for the agreed amount for services rendered, as stated in the verification of benefits, or agreed to private cash pay rate. By signing below, I agree to allow Dr. Carr Physical Therapy, Inc. to charge my credit card for the services rendered. I understand that this information is to be kept private and secure by Dr. Carr Physical Therapy.

_____ **(Initial)** I understand Dr. Carr Integrative Physical Therapy requires **24 hour advanced notice for appointment cancellations or rescheduling.** If I cancel an "in office" appointment less than 24 hours or no show to an "in office" appointment, I agree to allow Dr. Carr Integrative Physical Therapy, Inc. to charge my credit card a cancellation fee equal to the normal cost of the in office treatment. If I cancel an "at home" appointment less than 24 hours or no show to an "at home" appointment, I agree to allow Dr. Carr Integrative Physical Therapy, Inc. to charge my credit card the normal cost of the visit as a cancellation fee.

Credit Card Type: VISA/MC **Card Zip Code:** _____ **Card CSV Code:**_____

Account Number: _____Expiration Date: _____

Cardholder Name:_____

Signature of Authorized Card Holder: _____

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Privacy Policy

Dr. Carr Integrative Physical Therapy is required by law to maintain the privacy of your protected health information. The information consists of all records related to your health, including demographic information, either created by Dr. Carr Integrative Physical Therapy or received by Erin Carr Physical therapy from you or other health care providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this policy. Dr. Carr Integrative Physical Therapy will abide by the terms of this policy or the policy currently used in effect at the time of use or disclosure of your health information.

Your personal information will be used to contact you for arranging appointments, properly bill you, and for evaluation and treatment purposes .

We may disclose your information without prior authorization for public health purposes, which is required by law, auditing and/or research studies.

If you provide us authorization and written permission to release your records, you may revoke this authorization at any time to cease further disclosure.

Dr. Carr Integrative Physical Therapy has the right to change the terms of this policy making any new provisions effective for all protected health information that we maintain. Patients may obtain the current or revised copy at any time.

Your Rights:

- You have to right to place restrictions on the use and/or disclosure of your health information
- You have the right to inspect and/or copy your health information
- You have to right to amend or submit corrections to your health information
- If you feel your privacy rights have been violated or you disagree with any decisions we have made regarding access or disclosure of your personal health information please contact the U.S. Department of Health and Human Services.

If you request a copy of your medical records, this must be submitted in writing. There will be a $10 clerical fee.

_____ **(Initial)** I have received & reviewed a copy of the privacy policy for Erin Carr Physical Therapy Inc.

Print Name: _____ **Date:** _____

Patient/Guardian Signature: _____

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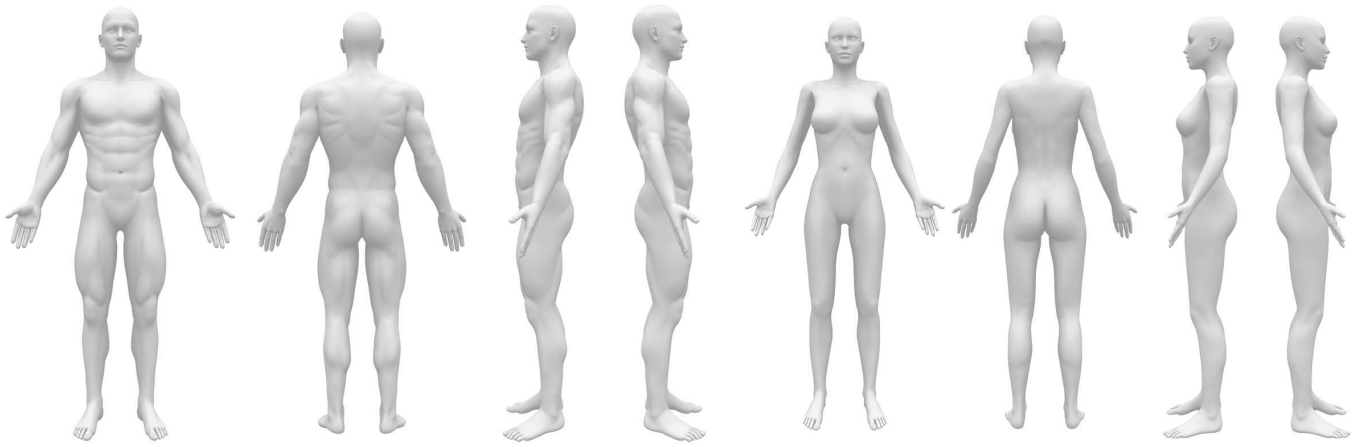
Health Questionnaire

This health questionnaire will help in the whole body evaluation process. An understanding of your medical history will aid in a thorough understanding of your health and its relation to your musculoskeletal system.

After printing this document, please mark with an (X) on the body chart where you experience your current symptoms. Please indicate on a scale of 0 -10, 0 being no pain and 10 being the worst pain your symptoms are currently.



Please select which of the following symptoms describe your current condition.

Ache☐ Sharp☐ Dull☐ Numb☐ Burning☐ Tingling☐

Catching☐ Popping☐ Clicking☐ Shooting☐ Stiffness☐ Loss of balance☐

Throbbing☐ Weak☐ Swollen☐ Heavy☐ Constant☐ Intermittent☐

Do you have difficulty with the following activities due to your current condition?

1. Sitting	○ Yes	○ No
2. Standing	○ Yes	○ No
3. Walking	○ Yes	○ No
4. Sleeping	○ Yes	○ No
5. Lifting (_____ lbs.)	○ Yes	○ No
6. Carrying	○ Yes	○ No
7. Reaching	○ Yes	○ No
8. Pushing/Pulling	○ Yes	○ No
9. Dressing	○ Yes	○ No

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Do you currently experience any of the following symptoms/conditions?

1.	Fever/Chills	○ Yes ○ No
2.	Fatigue	○ Yes ○ No
3.	Nausea/Vomiting	○ Yes ○ No
4.	Headaches	○ Yes ○ No
5.	Dizziness/lightheadedness	○ Yes ○ No
6.	Fainting/Loss of consciousness	○ Yes ○ No
7.	Double vision	○ Yes ○ No
8.	Ringing in the ears	○ Yes ○ No
9.	Difficulty swallowing	○ Yes ○ No
10.	High blood pressure	○ Yes ○ No
11.	Low blood pressure	○ Yes ○ No
12.	Chest pain	○ Yes ○ No
13.	Shortness of breath	○ Yes ○ No
14.	Asthma/Wheezing	○ Yes ○ No
15.	Diabetes	○ Yes ○ No
16.	Abdominal Cramping	○ Yes ○ No
17.	Ulcers	○ Yes ○ No
18.	Heartburn	○ Yes ○ No
19.	Bloating	○ Yes ○ No
20.	Constipation	○ Yes ○ No
21.	Diarrhea	○ Yes ○ No
22.	Indigestion/GERD	○ Yes ○ No
23.	Loss of Appetite	○ Yes ○ No
24.	Feeling of fullness	○ Yes ○ No
25.	Difficulty eating fatty/greasy foods	○ Yes ○ No
26.	Pain with urinating/bowel movement	○ Yes ○ No
27.	Urinary frequency	○ Yes ○ No
28.	Urinary Tract Infections	○ Yes ○ No
29.	Sinus congestion	○ Yes ○ No
30.	Coughing/Sneezing	○ Yes ○ No
31.	PMS	○ Yes ○ No
32.	Cramps during menstruation	○ Yes ○ No
33.	Skin rash/eczema/skin conditions	○ Yes ○ No
34.	Stroke	○ Yes ○ No
35.	Sleep disturbed by pain	○ Yes ○ No

Do you have any other medical issues or previous medical conditions not mentioned above?

_____

_____

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Are you under the care/supervision of an MD or DO for any current/related condition(s)?

_____

_____

Have you had any previous treatment for the current condition you are seeking treatment for?

_____

_____

Is this a work related injury? _____

Please describe your current level of function.

_____

_____

_____

Please list current medications.

_____

_____

Do you have a history of falling, tripping, stumbling?

_____

Do you have any environmental, food, or medication allergies?

_____

_____

Do you smoke? _____

Please list any additional pertinent information that may be related to your current condition.

_____

_____

_____