Dr. Carr Integrative Physical Therapy
ecarr@akashacenter.com
(323) 304-1602

Patient Information

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

Address: _____

City: _____ **State**: _____ **Zip**: _____

Home Phone: _____ **Ce**ll: _____**Work**: _____

SSN: _____ **Email Address:** _____

Occupation/Sport: _____

Spouse/Guardian: _____ **Relation to Patient**: _____

Address: _____ **City**: _____ **Zip**: _____

Home Phone Number:_____ **Cell:** _____

Emergency Contact: _____
Name Phone

Primary Physician:_____
Name Phone #

Diagnosis/Body Part: _____

How did you hear about us?

_____

_____

Patient/Guardian Signature: _____

Printed Name: _____ **Date**: _____

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Consent to Treat

_____ (Initial) I consent to have Dr. Carr Integrative Physical Therapy to provide physical therapy services in the Akasha Center or in my home/office according to the diagnosis by my physician. It is my responsibility to provide these prescriptions as needed throughout the plan of care to continue treatment. I understand that this consent may be changed, adjusted or revoked by me at any time.

Cancellation/No Show Policy

_____ (Initial) I agree that if I choose to cancel an appointment, I will do so **24** hours prior to my scheduled appointment. If I fail to agree, I will be responsible for paying the **$50** cancellation fee. If less than **24** hours notice is given OR you are not present at the time of your scheduled appointment due to an emergency, the **$50** charge can be waived at the discretion of your physical therapist.

Payment Policy

_____ (Initial) Dr. Carr Integrative Physical Therapy is a non-contracted provider for physical therapy services, therefore are considered out of network. It is my responsibility to pay the entire balance of my treatment at the time of treatment. I also understand if I purchase a package of sessions, it is to be paid in full on the first session.

I understand that Dr. Carr Integrative Physical Therapy cannot guarantee that services provided will be paid for by my insurance company. We advise that you contact your individual health insurance provider and ask if they cover physical therapy. If you do have physical therapy coverage, ask what percentage will be reimbursed for an "out-of-network" physical therapy treatment. Some insurance plans cover as much as 80% of fees so we really encourage patients to get in touch with their provider.

I understand I will be provided with a super bill and receipt after each treatment session that I can submit to my insurance company for potential reimbursement.

Privacy Policy

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

Patient/Guardian Signature: _____

Printed Name: _____ **Date**: _____

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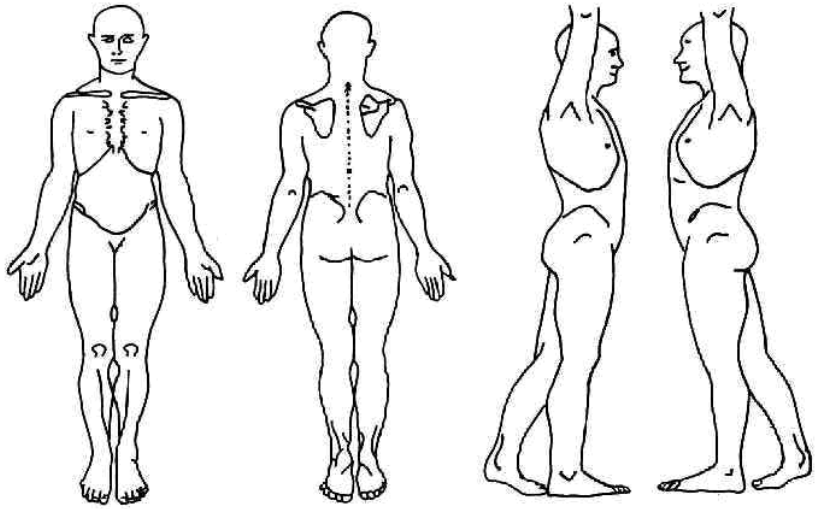
Health Questionnaire

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.

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 circle 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

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

_____

_____

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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.

_____

_____

_____

Patient Insurance Worksheet

Erin Carr Physical Therapy does **not** participate in any insurance networks. We will, however, offer guidance on how to manage your out-of-network benefits. We suggest that prior to your first visit you contact your insurance company to confirm your cover- age benefits. This form serves as a check-list to help you get all the necessary information in order to maximize your reimbursement.

Patient Name: _____

Primary Insurance Company: _____

Insurance ID#: _____ Group #: _____ Plan Type: _____

Insurance Tel#: _____ Insurance Effective Date: ____ / ____ / _____

Name of Person you are speaking with: _____

Time of Day: _____ Tracking ID for call: _____

How much is my out-of-network deductible? $_____

Is there Individual vs. Family deductible? Yes/No $_____

How much of my deductible has been met? $_____

What is my co-insurance percentage? 10% 20% 30% 40% other $_____

Does my policy require pre-certification (i.e.OrthoNet) for Physical Therapy services? Yes/No

If yes, Pre-Cert Phone#:_____ Pre-Cert Authorization #: _____

Number of Sessions allowed with this Pre-Cert: _____ Expiration Date: _____

How many out-of network physical therapy visits do I have? _____

Per year_____ Per year/per lifetime _____ Per Condition/per year _____

Is there a maximum amount/cap my plan pays for out-of-network physical therapy? Yes/No $_____

Number of PT visits already used this year:_____

Secondary Insurance:_____ Secondary Insurance ID#:_____

Secondary Insurance Tel#:_____ Effective Date: _____ / _____ / _____

Deductible $_____ Co-Insurance Payment %_____

I understand that I am responsible to obtain accurate information about my insurance policy in order to maximize my benefits. I also understand that I will pay for services at the time they are rendered and it will be my responsibility to seek reimbursement. Erin Carr Physical Therapy will provide documentation, such as evaluations and progress notes to assist you in this process.

If you need help or have any questions, please don't hesitate to call us at 323-304-1602.

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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.