Dr. Carr
Integrative Physical Therapy, Inc.
1238 7th Street Suite B
Santa Monica, CA 90401
(323) 304-1602
(323) 739- 3727
drcarr@erincarrpt.com

Patient Information

Name ____DOB ______________Age____

Address: ____

Phone Number _________________________ Email Address______________________

Occupation/Sport____

Spouse/Guardian____

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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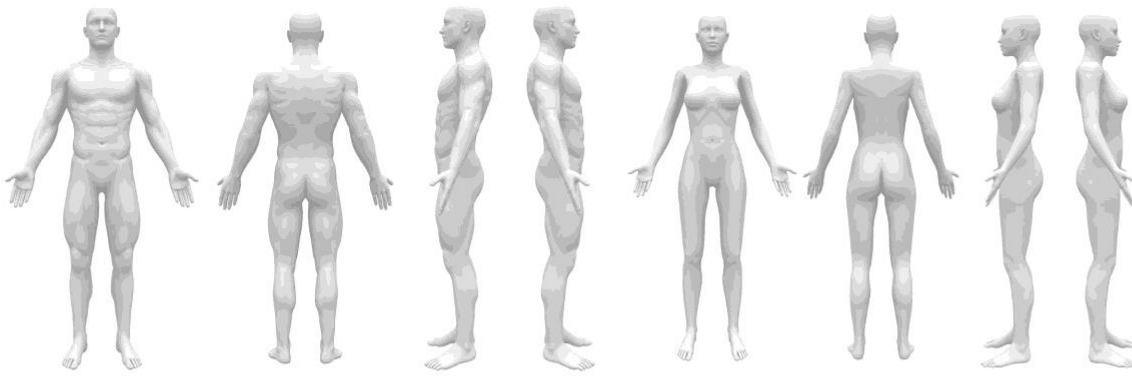
Health Questionnaire

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 circle which of the following symptoms describe your current condition.

Ache	Sharp	Dull	Numb	Burning	Tingling
Catching	Popping	Clicking	Shooting	Stiff	Loss of Balance
Throbbing	Weak	Swollen	Heavy	Constant	Intermittent

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

	(Circle Yes or No)	
1. Sitting	Yes	No
2. Standing	Yes	No
3. Sleeping	Yes	No
4. Walking	Yes	No
5. Stairs	Yes	No
6. Reaching	Yes	No
7. Carrying	Yes	No
8. Lifting (___lbs)	Yes	No
9. Push/Pull	Yes	No
10. Dressing	Yes	No

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Circle Yes or No if you currently experience any of the following:

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 infection	Yes	No
29. Sinus congestion	Yes	No
30. PMS	Yes	No
31. Cramping during menstruation	Yes	No
32. Skin rash/eczema/skin conditions	Yes	No
33. Stroke	Yes	No
34. Seizures	Yes	No
35. Headaches	Yes	No
36. Sleep disturbed by pain	Yes	No
37. Sudden weight loss	Yes	No
38. Fever/Chills	Yes	No
39. Inner thigh/groin numbness	Yes	No
40. Recent infection	Yes	No

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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? ____
____
____

Do you have a history of surgeries?
____
____

Please describe your current level of function.
____
____
____
____

Please list current medications, supplements, vitamins, minerals, etc.
____
____
____

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.
____
____
____

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Consent to Treat

I consent to have Dr. Carr Integrative Physical Therapy to provide physical therapy services at Dr. Carr Integrative Physical Therapy's Office, in my home or office. I hereby agree to participate in and consent to receive the physical therapy interventions recommended by my PT as outlined in my treatment plan. I understand that the response to different physical therapy interventions varies from person to person. Therefore, I agree to inform my PT of any change in my symptoms and function so my treatment plan can be adjusted accordingly. I understand that I may decline any intervention at any time by informing my PT of my desires/concerns and that my refusal may result in a termination of my treatment if my PT determines that there are no other treatment alternatives or the refused intervention is essential to meeting my goals. I also understand that although we have set rehabilitation goals, my PT has made no guarantees that any particular outcomes will result from the therapy interventions.

I have read this consent form, understand the benefits and risks involved in physical therapy, and agree to fully cooperate and participate in the proposed physical therapy interventions in the established plan of care.

Patient’s Name (Printed) ____

Patient’s Signature ____Date__________

Parent/Guardian Signature ____________________________________Date__________

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Consent for E-mail/Text Communication and Appointment Reminders

We respect the privacy rights of all our patients and will therefore only communicate with patients and parents/guardians through email, text or voice mail messaging with your written consent. Email can be inherently insecure if your email service does not use encryption. Also, if your email address is through your employer, your employer may have access to your email box. Voice mail may also be insecure, especially if you use a VOIP phone service. When you consent to communicating with us by email, text or phone, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information. Since we do not control the email and phone systems you use, we are not responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

- ☐ I do not consent to any voicemail, email or texting communication.
- ☐ I consent to receiving communication about the scheduling of appointments (limiting the information disclosed) by the following means: (check all that you consent to)
  - ☐ Email
  - ☐ Text
  - ☐ Voicemail
- ☐ I consent to all communication, including but not limited to communication about my medical condition and advice from my health care providers by the following means: (check all that you consent to)
  - ☐ Email
  - ☐ Text
  - ☐ Voicemail

E-mail address: ____

Phone number: ____

Patient Signature ____Date__________

Parent/Guardian Signature _________________________________Date__________

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Payment Agreement

Thank you for choosing Dr. Carr Integrative Physical Therapy, Inc. as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.

Payment is expected at time of service unless you have made other payment arrangements with us.

Out-of-Network Policy. (Commercial Health Plans) We are out-of-network with your health plan and you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.

Privacy Rights. You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. If you pay for your services at the time of service, we assume you are exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will disclose your health information.

Appeals Policy. You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.

Prevention, Wellness & Fitness Services. Most commercial health plans and Medicare do not cover the prevention, wellness or fitness services we offer. Therefore, we will provide you with a receipt for these services upon request.

I have read, understand and agree to these payment terms. I acknowledge that I have chosen, of my own free will, to obtain the services provided by Dr. Carr Integrative Physical Therapy, Inc. and have agreed to pay out of pocket for my services without any expectation that my health plan will reimburse me. If I am a Medicare beneficiary, I attest that I have chosen not to use my Medicare benefits for the services I am purchasing and am restricting Dr. Carr Integrative Physical Therapy, Inc. and my therapist from submitting any claims to Medicare pursuant to my right to privacy under HIPAA.

X ____ Date: ____________

Signature of Patient and/or Guardian

A photocopy of this agreement is to be considered valid, the same as if it was the original.

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Cancellation Policy

_________ (**Initial**) I understand Dr. Carr Integrative Physical Therapy requires **24-hour advanced notice for appointment cancellations or rescheduling**. When I schedule a one-hour in office or in-home physical therapy appointment with Dr. Carr Integrative Physical Therapy that time is reserved for me. When you do not provide a minimum of 24-hour notice of cancellation, this does not give your physical therapist the opportunity to offer your time to another patient in need of treatment. If I cancel an "in office" or “in home” 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 me. The cancellation fee is equal to the normal cost of the “in office” or “in home” treatment.

Credit Card Payments

I hereby authorize Dr. Carr Integrative Physical Therapy, Inc. to charge my credit card, debit card or HSA/FHA card **only** for the agreed amount for services rendered. 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.

Credit Card Type: VISA/MC/AMEX **Zip Code:** ______________ **CSV Code**______

Account Number: __________________________________ **Exp Date**: ____________

Cardholder Name:____

Authorized Card Holder Signature____

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