CARR PHYSICAL THERAPY CENTER

Date________________

PATIENT INFORMATION FORM

Patient's First Name		Mi:	Last Name		
Street Address (Students-Permanent Address):					Apt #:
City:	State	Zip	Birthdate	Age:	Sex: M/F
Home Phone	Business Phone		Cell Phone	Social security #	
Occupation			Marital Status S M W D Sep		
If Student, Where:		Parent's name:			
Patients Employer:		Parent's address			
City	State	Zip	E-mail address:		
Spouse Name	Emergency Contact		Emergency Contact Phone:		

Referral Information;

Primary Physician/Family Doctor	Address
	Phone
Treating Physician/Referring Specialist	Address
	Phone
How did you hear about us? (Friend, former patient, doctor, ad, drive-by, yellow pages, etc.)	
Do you have a return doctor appointment if so when?	

Insurance Information:

Worker's Comp. or Auto Accident	Name of insurance:	Address of Insurance		
	Claim#	Date of Injury:	Adjuster	Phone #
	Case in Litigation: yes / no	Attorney Name:	Attorney Phone #	

PATIENT NAME:______________________________ DATE:__________

Height__________ **Weight**__________

1.CURRENT CONDITION(S)/CHIEF COMPLAINT(S)

A. Describe the problem(s) for which you seek physical therapy:
____
____

B) When did the problem(s) begin (date):______________________________

C) What happened?______________________________
____

D) Have you ever had the problem(s) before?

(1)_____yes

A)What did you do for the problem(s)? ______________________________

B) Did problem(s) get better? _____yes _____no

C) About how long did the problem(s) last?______________

(2)_____no

E) How are you taking care of the problem(s) now?______________________________
____

F) What makes the problem(s) better?______________________________

G) What makes the problem(s) worse?______________________________

H) What are your goals for physical therapy? ______________________________
____

I) Are you seeing anyone else for the problem(s)? (Check all that apply)

(1)________ Acupuncturist
(2)________Cardiologist
(3)________Chiropractor
(4)________Dentist
(5)________Family Practitioner
(6)________Internist
(7)________Massage therapist
(8)________Neurologist
(9)________Obstetrician/gynecologist
(10)______Occupational therapist
(11)______Orthopedist
(12)______Osteopath
(13)______Pediatrician
(14)______Podiatrist
(15)______Primary care physician
(16)______Rheumatologist
Other:____________________

2. With whom do you live: a)____Alone b)_____Spouse Only c) _____Spouse and other(s)
d)_____Child e)_____Other relative(s) f)____Personal care attendant
g)_____Other:__________

3. Functional Status/Activity Level (Check all that apply)

A)_____Difficulty with locomotion/movement:

(1)_____Bed mobility
(2)_____Transfers (such as moving from bed to chair, from bed to commode)
(3)_____Gait (walking)

A)____On level
B)____On stairs
C)____On ramps
D)____On uneven terrain

B)______Difficulty with self-care (such as bathing, dressing, eating, toileting)

C)______Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)

D)______Difficulty with community and work activities/integration

1)______Work/School 2)_______Recreation or play activity

4. MEDICATIONS:

A) Do you take any prescription medications? (1)_____yes (2)_______no

If yes please list:______________________________
____

B) Do you take any non-prescription medications? (Check all that apply)

(1)_____Advil/Aleve
(2)_____Antacids
(3)_____Ibuprofen/Naproxen
(4)_____Antihistamines
(5)_____Aspirin
(6)______Decongestants
(7)______Herbal supplements
(8)______Tylenol
(9)_____Other:______________
____

C) Have you taken any medications previously for the condition for which you are seeing the physical therapist? (1)_____yes (2)______no If yes, please list:______________

5. Who referred you to Physical Therapy? ______________________________

PATIENT NAME:____ DATE:______________________

6. MEDICAL/SURGICAL HISTORY:

A) Please check if you ever had:

(1)______Arthritis
(2)______Broken bones/fractures
(3)______Osteoporosis
(4)______Circulation/vascular problems
(5)______Heart Problems
(6)______Pace maker
(7)______High blood pressure
(8)______Stroke
(9)______Diabetes/high blood sugar
(10)_____Low blood sugar/hypoglycemia
(11)_____Depression
(12)_____Head injury
(13)_______Multiple sclerosis
(14)_______Muscular dystrophy
(15)_______Parkinson disease
(16)_______Seizures/epilepsy
(17)_______Allergies
(18)_______Thyroid problems
(19)_______Cancer
(20)_______Repeated infections
(21)_______Other:___________

B) Within the past year, have you had any of the following symptoms? (Check all that apply)

(1)______Chest pain
(2)______Heart palpitations
(3)______Cough
(4)______Hoarseness
(5)______Shortness of breath
(6)______Dizziness or blackouts
(7)______Coordination problems
(8)______Weakness in arms or legs
(9)______Loss of balance
(10)_____Difficulty walking
(11)_____Joint pain or swelling
(12)_____Pain at night
(13)______Difficulty sleeping
(14)______Loss of appetite
(15)______Nausea/vomiting
(16)______Difficulty swallowing
(17)______Bowel problems
(18)______Weight loss/gain
(19)______Urinary problems
(20)______Fever/chills/sweats
(21)______Headaches
(22)______Hearing problems
(23)______Vision problems
(24)______Other:___________

C) Have you ever had surgery? (1)_____yes (2)______no
If yes, please describe, and include dates:
______________________________________ Month/Year___________
__________________________________ Month/Year__________
__________________________________ Month/Year__________

For Women Only:

Trouble with your period? ____Yes ____No
Past Pregnancy? ____Yes ____No
Delivery (please circle): vaginal___ cesarean_____
Complicated pregnancies or deliveries? _____yes ____no
Pregnant, or think you might be pregnant? _____yes ____no
Other gynecological or obstetrical difficulties? _____yes ____no
If yes, please describe:____
____

7. Other Clinical Tests Within the past year, have you had any of the following tests?
(Check all that apply for this condition)

(1)____Angiogram
(2)____Arthroscopy
(3)____Biopsy
(4)____Blood Tests
(5)____Bone Scan
(6)____Bronchoscopy
(7)____CT scan
(8)____Doppler ultrasound
(9)____Echocardiogram
(10)____EEG
(11)____EKG
(12)____EMG
(13)_____Mammogram
(14)_____MRI
(15)_____Myelogram
(16)_____Nerve conduction velocity
(17)_____Pap Smear
(18)_____Pulmonary function test
(19)_____Spinal Tap
(20)_____Stool test
(21)_____Stress test
(22)_____Urine Test
(23)_____X-rays
(24)_____Other:_________________________

Patient Name________________________________ **Date:**______________________

HEIGHT________ **Weight**______

1. PLEASE RATE YOUR PAIN: (0 = none, 1 = minimal, 10 = severe)

At present: 1 2 3 4 5 6 7 8 9 10

At its worst: 1 2 3 4 5 6 7 8 9 10

At its best: 1 2 3 4 5 6 7 8 9 10

2. How often do you experience symptoms?
   (1) Constantly (76-100% of the day)
   (2) Frequently (51-75% of the day)
   (3) Occasionally (26- 50% of the day)
   (4) Intermittently (0-25% of the day)

3. What describes the nature of your symptoms?
   (1) Sharp (4) Shooting
   (2) Dull Ache (5) Burning
   (3) Numb (6) Tingling

4. How are your symptoms changing?
   (1) Getting better
   (2) Not changing
   (3) Getting worse

5. In general would you say your overall health right now is.......
   (1) Excellent (2) Very Good (3) Good (4) Fair (5) Poor

6. Have you had similar symptoms in the past? (1) yes (2) no

A. If you have received treatment in the past for the same or similar symptoms, who did you see?
   (1) This Office (3) Physical Therapist (2) Chiropractor (4) Medical Doctor
   Other:_______________________________

7. Have you had any Physical Therapy this year? __yes ___no How many treatments? ______

Kindly let us know with whom we may share your health information by filling out the following section.

I ___________________ allow the release of information regarding my care and attendance at Carr Physical Therapy to the undersigned person(s). I understand in doing so that Carr Physical Therapy Center is within compliance of HIPPA Guidelines.

1.__________________________Relationship to patient______________

2.__________________________Relationship to patient______________

3.__________________________Relationship to patient______________

4.__________________________Relationship to patient______________

Carr Physical Therapy Center
Office Policies

Scheduling

When using insurance, a current prescription signed by a medical doctor, and updated every 30 days, is required for treatment. If treatment continues for a prolonged period, prescriptions must be updated regularly with your medical doctor. You are responsible for these updates. Let us know when you will be seeing your physician so we can have a progress report ready.

A Word About Insurance

We accept many health plans as either an in-network or out of network provider. If you have a personal injury/automobile accident with individual coverage or have a Worker's Comp injury, we will submit these claims and bill directly for you based on our ability to obtain prior authorization for your treatment.

Physical therapy coverage is often confusing. Although we can assist you with your insurance questions, it is strongly suggested that you contact your insurer directly to determine your coverage for out-patient physical therapy. You may be required to make deductible or co payment payments as part of your coverage. Customary method of billing for physical therapy services is based on the amount and type of services you receive; therefore we cannot tell you exactly how much your treatment will cost. However; once we have verified your coverage, we can notify you of your approximate coverage. Please feel free to talk to our billing staff regarding your insurance questions.

You may or may not carry insurance under which a percentage of our fees are covered. You should know that all professional services provided by Carr Physical Therapy Center are charged directly to the patient, and that he or she, (or the financially responsible party) is personally responsible for payment. While we cannot render services on the assumption that our fees will be paid by an insurance company, we will prepare insurance claim forms to confirm services payable to your insurance company.

Patients are responsible for services not covered by insurance; including care that the insurance deem is **"not medically necessary"** even though a physician may recommend treatment.

Overall, patient are ultimately responsible for knowing the details of their coverage (e.g., percent of coverage, deductible, co - payments, limits on number of visits or dates of coverage, your referring physician or our status as s preferred provider, etc.) which may determine the extent of your financial responsibility.

We do not accept liens against pending litigation settlements.

Financial Payment Arrangements

It is our policy in this office to maintain your account on a current basis. **We ask that you make co-payments, co-insurance and deductibles at the time of each visit.** We carry an automatic 15% late charge on accounts that are 90 days past due.

**** Any supplies that are provided to you at this clinic are not covered by insurance companies. We require payment of these supplies at the time they are given to you.**

Voluntary Termination of Care

It is the policy of this office that if you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you and will be immediately due and payable.

It is the patient's responsibility:

- To know their insurance policy. Patients should be aware of their benefit coverage including which health care providers are contracted with their plans, covered and non-covered benefits, authorization requirements and cost share information such as deductibles, coinsurances and co-payments. If you are not familiar with your plan we suggest you contact your carries directly.
- To obtain a referral from their Primary Care Physician (PCP). Any non-covered services are the financial responsibility of the patient.
- To pay co-payments at the time of service, estimated co-insurance amounts and deductibles.
- To promptly pay any patient responsibility indicated by their insurance carrier.
- To facilitate in claims payment by contacting their insurance carrier when claims have not been paid.

Carr Physical Therapy Center

Office Policies
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It is Carr Physical Therapy Center's responsibility:

- To provide quality medical care.
- To file insurance claims as a courtesy to the patient. A 60-day period will be extended for pending insurance payment, after which the patient may be responsible for the entire balance.
- To provide a superbill for submission to insurance if we are not part of insurance network.

Cancellations and No-Shows

If possible, we require 24 hours notice in the event of cancellation. There is a $25 service fee for no-shows without proper notice. This charge is not covered by your insurance and is billed directly to the patient, and will be collected at the time of the next scheduled visit. Repeated missed appointments may warrant discontinuance of care.

Appointment Policy

Your appointment times are critical to your rehabilitation and success in physical therapy. It is the policy of this facility, and tour responsibility to adhere to the following appointment protocol.

- If you DO NOT SHOW UP 1x, we will call and ask for a return call
- If you DO NOT SHOW UP 2x, we will call and ask for a return call
- After your 3rd NO SHOW, you will be considered discharged and we will notify your physician and/or your Worker's Comp Carrier.
- To be re-instated into physical therapy, you will be required to be re-evaluated by your physician and present in this clinic with a new prescription.

Financial Policy Acknowledgement:

I have read and understand the above financial and appointment policies. I agree to pay the No-Show fee and understand, that regardless of my insurance claim status or absence of insurance coverage, I an ultimately responsible for the balance on my account for any services rendered.

______________________________ ________________

Patient or Responsible Party Signature Date

Release of Medical Information and Assignment of Benefits:

I authorize the release of medical information for filing health insurance claims for me by Carr Physical Therapy Center. I also authorize my insurance carrier(s) to may payment directly to Carr Physical Therapy Center.

______________________________ ________________

Patient or Responsibility Party Signature Date

I have read and agree to the above policies.

______________________________ ________________

Patient/Guardian Signature Date

Carr Physical Therapy Center

HIPPA Regulations

Privacy Practices

The privacy of out medical information is important to us. We understand that you medical information is personal and we are committed to protecting it. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Our Legal Duty

The law requires us to 1) Keep your medical information private. 2) Give you notice describing our legal duties and privacy practices. 3) Notify you of any changes in our privacy practices.

Use and Disclosure

To follow are different ways that we are permitted to use and disclose medical information. We will not use or disclose any medical information not listed without specific written authorization from you.

Treatment: We may use medical information about to you provide you with medical treatment or other services related to your care. We may disclose medical information about you to doctors, nurses, technicians or other people involved in your care. We may also share medical information about you to *your* other health care providers to assist them in treating you.

Payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or third party payor (i.e., insurance company, attorney, consulting physician). We may also disclose information to your health plan about treatment or possible treatment to help determine us your health care will pay for certain services.

If you have any questions about any of our policies or your rights, please speak with your physical therapist or any of our staff.

Your signature below indicates your understanding and compliance of the above privacy practices.

Printed Name ______________________ Date ______________

Signature ______________________