

# Patient Express Registration

## Walker Physical Therapy

Today's Date:

### 1. Personal Info

Please Fill-Out Entire Form Completely & Legibly.

\_\_\_\_\_  Male  Female

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Age \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

( \_\_\_\_\_ ) ( \_\_\_\_\_ )

Home Phone \_\_\_\_\_ Cellular \_\_\_\_\_ Email Address (Important) \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_ Phone # \_\_\_\_\_ (if minor) Parent/Guardian Name and Signature \_\_\_\_\_

Occupation \_\_\_\_\_ Employer Name \_\_\_\_\_ Phone # \_\_\_\_\_

My condition is related to:  Work  Auto Accident (State \_\_\_\_\_)  Other \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Single  Married

Work Status:  Currently Employed:  Retired  Disabled ( \_\_Total or \_\_Temporary)  Student ( \_\_P/T \_\_F/T)

### 2. Referral Info

ALL INFO REQUIRED\*\*

How did you hear about us?

If by a friend or family member, please give their phone number and address below that we may send a thank you note and small gift.

\_\_\_\_\_  
\_\_\_\_\_

Primary or Referring Physician Name

Street Address

City State Zip

Phone Fax

Email Address

Do you have a followup appointment with this physician? \_\_\_\_\_  
If yes, when? \_\_\_\_\_

### 3. Payment Info

(check only one box)

I am paying by **CASH, CHECK, CREDIT** and would like a . . .

- 30% discount by paying at the time of service.
- Payment plan. Fees may apply.

I have **INSURANCE** and would like to . . .

- Have you deal directly with them. I will assign my benefits to you by completing the "Assignment of Benefits Form". Fees may apply. The following information is required prior to 1st visit.  
My coinsurance/copay is \$ \_\_\_\_\_  
My deductible is \$ \_\_\_\_\_
- Get a 30% discount by paying the entire bill at the time of service. I'll get reimbursement on my own.  
(Ask the front desk person for details)

I have an **ATTORNEY** and would like to . . .

- Get a 30% discount by paying up front. I'll get reimbursed after my case settles.
- Wait until my case settles before paying. I will complete the "Attorney Lien" form. Fees may apply.

### 4. Credit Card on File

Safe and Secure. I understand I will be notified of any and all charges prior to processing.

\_\_ Visa \_\_ MC \_\_ AmerX \_\_ Discover Card # \_\_\_\_\_

Name on Card \_\_\_\_\_ Exp Date \_\_\_\_\_ CVV code \_\_\_\_\_

# Physical Therapy Initial Evaluation

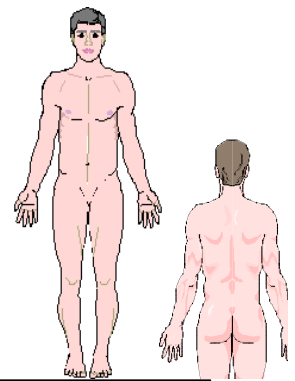
*In order to evaluate your condition fully, please be as accurate as possible. Thank you.*

1. What is your age? \_\_\_\_\_
2. What is your gender?  Male  Female
3. What is your occupation? \_\_\_\_\_  
- Are you working now?  Yes  No
4. Have you had physical therapy before?  Yes  No
5. Where is your pain/problem? \_\_\_\_\_
6. What caused your pain/or problem? \_\_\_\_\_
7. Approximately when did it start? \_\_\_\_/\_\_\_\_/20\_\_\_\_
8. Is it getting worse, better, or staying the same? \_\_\_\_\_
9. Have you ever had this pain/problem before?  Yes  No  
\_\_\_\_\_

10. Is your pain constant (never goes away)?  Yes  No
11. On the scale below circle your worst pain level in the past couple of days:

*Mild*                      *Moderate*                      *Severe*  
0 ... 1 ... 2 ... 3 ... 4 ... 5 ... 6 ... 7 ... 8 ... 9 ... 10

12. Are you taking any medication for this pain/problem?  Yes  No  
- If yes, what and does it help?
13. Are any of your usual everyday activities affected?  Yes  No  
- If yes, describe how.



14. Draw your pain in the diagram to the right. Circle areas of numbness or tingling.  
\_\_\_\_\_

15. List all past surgeries with dates:
16. List all medical conditions you have (or were told you have)?

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Referring MD: \_\_\_\_\_

## Important Company Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial , and indicate your agreement by signing at the bottom.

**Please Initial**

### **Late Policy “10-minutes”**

Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

### **24-Hour Advance Notice Fee**

If you wish to change or cancel an appointment we require a minimum **24-hour advance notice**. Anything less will result in a **\$10 fee** charged to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you the actual cost for that appointment but rather a mere **\$10 fee**. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

### **Copays are due upon arrival**

If you happen to forget your wallet or checkbook we may still be able to see you upon completion of an “Extension Request” form. This is a “promise-to-pay” form and carries a minimal fee that allows you to keep your appointment.

### **No-shows are bad**

If you fail to show for an appointment without notice all future appointments will be removed and a **\$10 fee** assessed to your account. You may re-schedule appointments again on a “first come, first serve basis”.

### **Cell phones must be shut OFF or silent.**

We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. Thank you.

### **Children requiring supervision are NOT allowed to attend sessions with you.**

Unless your facility offers child care services, you may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

### **Financial Hardship**

If you are experiencing financial difficulties and are unable to afford the cost of our services we have a “Financial Hardship Form” which may be filled-out. If you qualify for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill. Ask the front desk person for assistance.

**Important Notice from the Federal Government:**“It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments . . . even if your doctor allows it. Unless you complete a “Financial Hardship” form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as “professional courtesy” and “TWIP’s - Take what insurance pays”. Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General, Department of Health and Human Services. Contact by phone: 202 619-1343, by fax: 202 260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General, 202 619-0089.”

***We look forward to building a successful relationship with you that lasts a lifetime!***

I have read and agree to all the policies on this form.

Signed \_\_\_\_\_



# Assignment of Benefits to Walker Physical Therapy

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_ ID # \_\_\_\_\_

Insurance Policy #: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Insured Date of Birth \_\_\_\_\_

Your relationship to the Insured:  Parent  Spouse  Other: \_\_\_\_\_

Claim # \_\_\_\_\_

I hereby instruct and direct \_\_\_\_\_ insurance company to pay by check made out and mailed to:

**Walker Physical Therapy**  
**1111 W. Town and Country Rd. Ste. 1**  
**Orange, CA 92868**  
**714-997-5518**

If my/this current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

## **This is a direct assignment of my rights and benefits under this policy.**

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- A photocopy of this Assignment shall be considered as effective and valid as the original.
- I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- I authorize the use of this signature on all insurance submissions.
- I authorize Walker Physical Therapy to deposit checks made in my name.
- I authorize Walker Physical Therapy to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature of Policyholder

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Claimant, if other than Policyholder

**Pre-Exam Form** Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer (if applicable) \_\_\_\_\_

I agree to give honest and accurate answers: Yes \_\_\_\_\_ No \_\_\_\_\_

1	What is wrong? What are you unable to do?	
2	What caused your problem (or think is causing it)?	
3	In your understanding, what do you think will make you better?	
4	What are some potential obstacles to you getting better?	
5	How optimistic are you that you'll get better?	(Please circle one) Not at all   Mildly optimistic   Fairly   Very optimistic   Extremely
6	Over the next month, how many hours/week will you commit to getting better?	
7	What are you expecting from your physical therapy program?	

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/therapist will determine whether or not I am a viable candidate for a rehabilitation program and that my activation into their system is not guaranteed.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**Walker Physical Therapy**  
**PATIENT CONSENT FOR TREATMENT**

The treatment plan and goals were presented and discussed with me. The risk, if any, associated with the proposed treatment as well as alternatives to the proposed treatment were presented and explained to me. It is my responsibility to keep my scheduled appointments in order to receive optimal benefits from my therapy. My signature verifies my understanding and consent for treatment of my condition by Walker Physical Therapy.

Patient Name (PRINT) \_\_\_\_\_

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

Therapist's signature \_\_\_\_\_ Date \_\_\_\_\_

# DISABILITIES OF THE ARM, SHOULDER AND HAND

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

# DISABILITIES OF THE ARM, SHOULDER AND HAND

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, <i>to what extent</i> has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? ( <i>circle number</i> )	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? ( <i>circle number</i> )	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. (*circle number*)

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? ( <i>circle number</i> )	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. ( <i>circle number</i> )	1	2	3	4	5

**DASH DISABILITY/SYMPTOM SCORE** = \_\_\_\_\_ ( [(sum of n responses / n) - 1] x 25, where n is the number of completed responses.)

A DASH score may not be calculated if there are greater than 3 missing items.