Patient Express Registration

Walker Physical Therapy

Todays 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. Referrral 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

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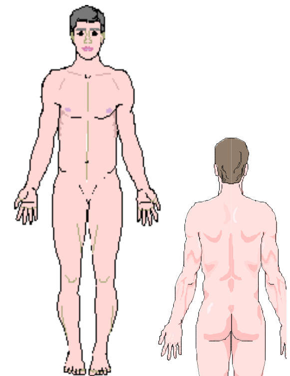
10. Is your pain constant (never goes away)? Yes No
11. On the scale below <u>circle</u> your worst pain level in the past couple of days:

    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.



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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 quality 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 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____

Walker Physical Therapy

Statement of Privacy Notice

Effective June 1, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (951) 279-0777. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (951) 279-0777. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Walker Physical Therapy with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

____
Patient's Name (print)

____
Patient's Signature Date

____
Authorized Facility Signature Date

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 ______

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb Problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	**Extreme Difficulty or Unable to Perform Activity**	**Quite a Bit of Difficulty**	**Moderate Difficulty**	**A Little Bit of Difficulty**	**No Difficulty**
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE: _____/ 80

Please submit the sum of responses to ACN.

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