

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

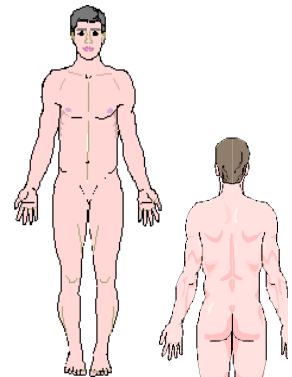
In order to evaluate your condition fully, please be as accurate as possible. Thank you.

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: _____

**WALKER PHYSICAL THERAPY
INITIAL EVALUATION PART 1
INITIALS _____**

PHYSICAL THERAPIST

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 _____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ⓪ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

Sleeping

- ⓪ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- ⓪ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

Concentration

- ⓪ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

Work

- ⓪ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

Personal Care

- ⓪ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

Driving

- ⓪ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

Recreation

- ⓪ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

Headaches

- ⓪ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck
Index
Score