

# Patient Express

# Registration

Walker Physical Therapy

Today's Date:

<b>1. Personal Info</b>				
<i>Please Fill-Out Entire Form Completely &amp; Legibly.</i>				
Last Name _____		First Name _____		Age _____ <input type="checkbox"/> Male <input type="checkbox"/> Female
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: <input type="checkbox"/> Work <input type="checkbox"/> Auto Accident (State _____) <input type="checkbox"/> Other _____				
Social Security # _____		Date of Birth _____ / _____ / _____		<input type="checkbox"/> Single <input type="checkbox"/> Married
Work Status: <input type="checkbox"/> Currently Employed: <input type="checkbox"/> Retired <input type="checkbox"/> Disabled ( __Total or __Temporary) <input type="checkbox"/> Student ( __P/T __F/T)				

<b>2. Referral Info</b>	<i>ALL INFO REQUIRED**</i>
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 follow-up appointment with this physician? _____	
If yes, when? _____	

<b>3. Payment Info</b>	(check only one box)
I am paying by <b>CASH, CHECK, CREDIT</b> and would like a . . .	
<input type="checkbox"/> 30% discount by paying at the time of service. (If we are contracted with your insurance company and you are planning to submit your bills to them, a 30% discount is not available. We are obligated by your insurance company to charge you the contracted rates.)	
<input type="checkbox"/> Payment plan. Fees may apply.	
I have <b>INSURANCE</b> and would like to . . .	
<input type="checkbox"/> 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 \$ _____	
I have an <b>ATTORNEY</b> and would like to . . .	
<input type="checkbox"/> Get a 30% discount by paying up front. I'll get reimbursed after my case settles.	
<input type="checkbox"/> Wait until my case settles before paying. I will complete the "Attorney Lien" form. Fees may apply.	

<b>4. Credit Card on File</b>	<i>Safe and Secure. I understand I will be notified of any and all charges prior to processing.</i>
___ Visa ___ MC ___ AmerX ___ Discover      Card # _____	
Name on Card _____ Exp Date _____ CVV code _____	

# 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 My Benefits

IMPORTANT: All information must be completed or we will NOT be able to do the courtesy of dealing directly with your insurance plan.

## Benefit and Policy Info

Patient portions are estimated and collected based on your insurance worksheet and the contracted rate with individual insurance companies. Walker Physical Therapy bills for its services, however, at one standard fee to all payors. Rate adjustments are not applied until after the receipt of an explanation of benefits from contracted payors. Upon receipt of an insurance explanation of benefits, the patient's portion is finalized and patient pre-payments are applied accordingly.

I hereby instruct and direct \_\_\_\_\_ insurance company to **pay by check made out to the "healthcare provider" to the right and mailed to** the address on the right (not mine). If my/this current policy prohibits direct payment to doctor/therapist, 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. If this is an auto accident, I will make sure my attorney will not override any insurance payments due to Walker Physical Therapy.

Walker Physical Therapy  
1111 W. Town & Country Rd. Ste.1  
Orange, CA 92868  
(800) 916 - 6210

### **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, of other than Policyholder



**Walker Physical Therapy**  
**IMPORTANT NOTICE FOR ALL MEDICARE PATIENTS**

Walker Physical Therapy must be informed if you are receiving any form of treatment through a Home Health Care agency. If you are currently under the care of a Home Health Care provider, Medicare will not pay for services at an outpatient Physical Therapy facility. Therefore, we will be unable to treat you at this time so please notify your referring physician.

Your signature verifies that you are **NOT** receiving Home Health Care at this time. Failure to disclose this information will render you financially responsible for all charges incurred at Walker Physical Therapy.

Walker Physical Therapy must be informed if you have had any physical therapy or speech therapy in this calendar year. Currently, Medicare has a cap of \$1810 per calendar year per patient for both physical therapy and speech therapy.

Have you had any physical therapy or speech therapy this year? \_\_\_\_Yes \_\_\_\_No  
If yes, please list the dollar amount \$\_\_\_\_\_

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

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(A) Notifier(s):  
(B) Patient Name:

(C) Identification Number:

## ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

**NOTE:** If Medicare doesn't pay for (D) physical therapy services listed below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D) services over the pt cap limit below.

What Medicare May Not Pay:	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:
Physical therapy services exceeding your capitation limit as set forth by Medicare. Approximately 12 visits are covered by Medicare.	Physical therapy capitation limits	Based on services rendered

### WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D) physical therapy services listed above.

**Note:** If you choose option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

### (G) OPTIONS: Check only one box. We cannot choose a box for you.

**OPTION 1.** I want the (D) physical therapy services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

**OPTION 2.** I want the (D) physical therapy services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

**OPTION 3.** I don't want the (D) physical therapy services listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

### (H) Additional Information:

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:

(J) Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/08) Form Approved OMB No. 0938-0566

# Medicare Patient Insurance Worksheet

We accept all insurances that have in and out-of-network benefits. If you do not have insurance benefits for physical therapy, please call us at 714-997-5518 to discuss our popular payment plans and generous discount programs. We also have payment plans for patients with high deductibles.

**For accurate information call the member services toll free number on your card. Make sure you speak to a human being, do not use the automated system. Please call us at 714-997-5518 after you obtain your benefits information.**

Name of person you are speaking with \_\_\_\_\_ Time of day \_\_\_\_\_  
Tracking ID for the call or representative ID \_\_\_\_\_

1. Is your Medicare associated with an HMO? (eg: Medicare Advantage & Blue Shiled 65+)

\_\_\_ YES \_\_\_ NO

2. How much is my deductible? \_\_\_\_\_

3. How much of my deductible has been met? \_\_\_\_\_

4. Have you had any physical therapy, speech therapy or occupational therapy this year?

\_\_\_ YES \_\_\_ NO If yes, what dollar amount has been used for each?

\$ \_\_\_\_\_ PT \$ \_\_\_\_\_ Speech \$ \_\_\_\_\_ OT

5. Do you have a secondary insurance? \_\_\_ YES \_\_\_ NO

If yes, please call to verify your benefits and ask the following questions.

6. Name of your insurance \_\_\_\_\_

7. Is this a supplemental insurance? \_\_\_ YES \_\_\_ NO

8. Will your secondary insurance cover the cost of your treatment after Medicare cap is met

and Medicare denies payment? \_\_\_ YES \_\_\_ NO

I understand that I am responsible for obtaining accurate information about my insurance benefits so that Walker Physical Therapy can bill them correctly on my behalf. If the above information is inaccurate, I will be responsible for paying the balance for my visits to Walker Physical Therapy. I understand that Walker Physical Therapy is not an HMO provider.

**Patient Signature:** \_\_\_\_\_

If you need help or have any questions, please don't hesitate to call us at 714-997-5518.  
*We look forward to helping you get the results you desire.*