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. *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 out of pocket by **CASH, CHECK, CREDIT** and would like a . . . .

❑ 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 $__________

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

❑ 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 ___AmeX ___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 height? _______ What is your weight? _______
4. What is your occupation? _______________
   - Are you working now? ☐ Yes ☐ No
5. Have you had physical therapy before? ☐ Yes ☐ No
6. Where is your pain/problem? _______________
7. On the scale below circle your worst pain level in the past couple of days:

   None *Moderate* *Severe*

   At worst: 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

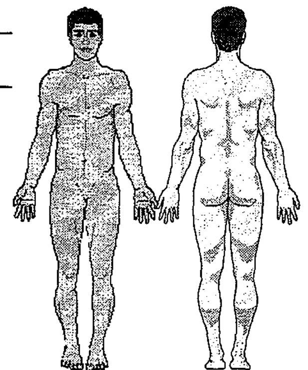
   Current: 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

   At best: 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

   Pain Description: _______________
8. Are you taking any medication for this pain/problem? ☐ Yes ☐ No
   - If yes, **what**: _______________

   And does it help? ☐ Yes ☐ No
9. Is your pain constant (never goes away)? ☐ Yes ☐ No
10. What caused your pain/or problem? _______________
11. Approximately when did it start? ____/____/20____
12. Is it getting worse, better, or staying the same? _______________
13. Have you ever had this pain/problem before? ☐ Yes ☐ No
14. What is wrong? What are you unable to do? _______________

    ____
15. Are any of your usual everyday activities affected? ☐ Yes ☐ No
    - If yes, describe how.
16. Draw your pain in the diagram to the right. Circle areas of numbness or tingling.



17. List all past surgeries with dates:
18. List all medical conditions you have (or were told you have)?
19. How optimistic are you that you'll get better? (please circle one)

    Not at all Mildly Optimistic Fairly Very Optimistic Extremely

I, the undersigned, give my consent to ancillary services performed by Walker Physical Therapy (discuss w/ therapist)

___830 Laser ___Percussor ___Other

Patient Name:_______________ Date:_______________

Signature:_______________ Referring MD:_______________

Physical Therapist Initials______

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 verification 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
(714) 997-5518

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 if my insurance provider should choose to make payments in this manner.
- ☐ 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 $1,920 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 $______________ and number of visits ________________

Patient Name (PRINT) ________________________________

Patient's Signature: ___________________________________ Date: _______________

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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 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 (714) 997-5518. 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 (714) 997-5518. 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