

# 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 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? \_\_\_\_\_  
\_\_\_\_\_

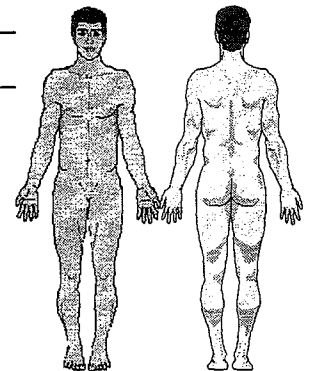
15. Are any of your usual everyday activities affected?  Yes  No  
- If yes, describe how.

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: \_\_\_\_\_

# 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

## 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 \_\_\_\_\_

