

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 follow-up 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. (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)

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 . . .

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 _____

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

Patient Insurance Worksheet

We accept all insurances that have in an 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. How much is my deductible for Physical Therapy? _____
2. How much of my deductible has been met? _____
3. What is my co-insurance percentage? (ie:40%, 30%, 20%) _____
4. Does my policy require pre-authorization for physical therapy services? Y/N
5. How many physical therapy visits do I have left for this year? _____
6. Is there a max \$ cap that my plan pays for physical therapy? Y/N
7. What is the billing address for your insurance?

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.

If you need help or have any questions, please don't hesitate to call us at 714-997-5518.

Patient Signature: _____

We look forward to helping you get the results you desire.

Patient Agreement of Walker Physical Therapy Financial Guidelines for Motor Vehicle Accident Patients

We need the following information and your signature if you are being treated for an auto accident.

Patient Name: _____ Attorney Name: _____
Referring Doctor: _____ Attorney Address: _____
Date of Injury: _____
Attorney Phone #: _____

Patient's Own Insurance Company

Address: _____ Claim# _____
_____ Med Pay Amount: _____
Adjuster Name: _____ Deductible: _____
Phone # _____

If Excess Med Pay Policy, Name of Health Insurance: _____

Health Insurance Address: _____

Health Insurance Phone #: _____

Health Insurance Verification Date: _____

Will auto insurance cover for deductible and co-pay? Yes or No

Will the auto insurance need Explanation of Benefit from Health Insurance? Yes or No

I, the undersigned, understand that Walker Physical Therapy does not bill third party insurance. As a courtesy, WPT will bill my own auto or health insurance for its services to me. However, it will be my responsibility to see that my own auto or health insurance reimburse Walker Physical Therapy directly for services provided to me.

I have signed an assignment of insurance benefits to WPT, which must be honored. If my insurance does not pay Walker Physical Therapy in full within 90 days of billing, I expressly authorize Walker Physical Therapy to obtain the full remaining amount from my credit card listed below. Should I obtain an attorney, or if I have an attorney now for my injury, I will make sure my attorney will not override any insurance payments due to Walker Physical Therapy. I understand that Walker Physical Therapy will release all medical records needed by my attorney, or to anyone who requests them in writing, in order to ensure or settle any litigation. I understand that it is ultimately my responsibility to see that Walker Physical Therapy be paid in full for all services rendered to me.

Patient Signature

Date Signed

Type of Credit Card: _____

Credit Card #: _____

Expiration Date: _____

Authorized Signature: _____

Date: _____