# Wallace Physical Therapy

(Registration Form)

Patient Name: _____ Responsible Party: _____

Mailing Address: _____ City, State, Zip: _____

Perm Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Sex: _____ D.O.B: _____ Age: _____ Patient SS#: _____

Responsible Party SS#: _____ Relationship to patient: _____

Emergency Contact Name: _____ Address: _____

Emergency Phone: _____ Injured on the job: _____

Personal Injury: _____ Attorney: _____

Phone/Address: _____ Patient E-mail Address:

_____

## Primary Insurance

Co. Name: _____

Policyholder's Name: _____

Rel. to Patient: _____

Sex: _____ D.O.B: _____

ID #: _____

Group #: _____

## Secondary Insurance

Co. Name: _____

Policyholder's Name: _____

Rel. to Patient: _____

Sex: _____ D.O.B: _____

ID#: _____

Group #: _____

**Authorization to release information:** I hereby authorize the release of any medical information necessary to process my claims. In the event that a dispute arises regarding non-payment for services between my doctor and my insurance company, I give my permission for the AZ department of Insurance to access my medical records if necessary to resolve the matter. I also authorize my insurance benefits be paid to Robert Wallace Physical Therapy. I understand that I am financially responsible for non- covered services.

**I have been notified, if I miss an appointment without giving a 24 hour notice to WPT, I will be billed a $25.00 fee.**

Signed: _____ Date: _____

# Wallace Physical Therapy

## Primary Medicare Questionnaire

(Please circle your answer)

Have you been discharged from a hospital within 60 days? YES NO

If Yes please indicate what hospital and contact information if available:

_____

_____

Have you been discharged from home health care in the last 60 days? YES NO

If Yes please indicate by whom and contact information:

_____

_____

# Wallace Physical Therapy Billing Procedure
# Billing Service Is: Assurance Medical Management
# Account Manager Is Bambi. Call her @ 318-3500
# if you have any questions or concerns.

**Medicare Patients:**

Have a yearly deductible of: $147.00 and a total of $1,900.00 a year in coverage. Medicare does not pay for physical therapy that they feel is not a **medical necessity.** In order to be deemed a medical necessity, I need to obtain a new prescription from my referring physician **every 60 days and I must be seen in his or her office.** _____ **(Initial)**

If I do not update my prescription, I will be required to sign a GA waiver. (A GA waiver is a notification that the services I am receiving may not be paid by Medicare.) By signing the waiver, I agree that **the possibility of denial has been explained** and I am aware that if they do deny, I will be billed. _____ **(Initial)**

Claims are sent to Medicare; processing can take up to 60 days. If we have to appeal, it can take up to 6 months for the claims to be paid.

**Medicare with Secondary Patients:**

Medicare insurance has an 80/20% co-insurance. I understand that means I am responsible for the remaining 20% of my bill. If I have a secondary insurance, after Medicare has paid their 80% of my claim, my secondary will be billed **once as a courtesy. Wallace PT will not provide a "quote of benefits"** for my secondary insurance as that is my responsibility.

_____ **(Initial)**

**I understand I am responsible for the bill if my medical insurance does not pay.**

If my secondary insurance does not respond to Wallace's billing, then I will need to pay that bill and it will be up to me to get in touch with my secondary insurance for my reimbursement. _____ **(Initial)**

*Statements are sent once a month throughout the duration of your therapy. The balance of your statements will change as you and your insurance pay your contracted portions. Your statements may not always reflect the entire balance due if the treatment is still ongoing at the time of mailing. We do make payment arrangements for patients who need them. It is their responsibility to contact our billing office. If a payment plan is set up on your behalf, you need to make the promised payments by the monthly due date.*

*Once you have received 3 billing statements, and have made no payment attempts, you will receive a final notice. You will then have ten (10) days to respond. If you do not respond to the final notice, you will be referred to collections. Once you have been referred to collections, we cannot reverse that situation. It will become your responsibility to contact the collection agency and make payment arrangements with them. It is ultimately your responsibility as the patient/insured to know and understand your insurance and benefit information. There is a customer service/benefits information number on your insurance card. If you have any questions, please call them.*

Signature: _____ Date: _____

**Name:** _____ **Date:** _____

**Purposes: To identify difficulties secondary to your dizziness/unsteadiness**
**If your problems are intermittent, your answers should reflect your "bad days"**

| You should respond: "Yes, Sometimes, No" | Yes | Sometimes | No |
|---|---|---|---|
| 1. Does looking up increase your problem? (Or bending over) | | | |
| 2. Because of this problem, do you feel frustrated? | | | |
| 3. Because of this problem, do you restrict your travel? | | | |
| 4. Does walking down the aisle of a supermarket increase your problem? (without the cart?) | | | |
| 5. With the problem, do you have difficulty getting into or out of bed? (must move slowly) | | | |
| 6. Does your problem significant restrict your participation in social activities? (outings) | | | |
| 7. Because of this problem, do you have difficulty reading? | | | |
| 8. Does performing more ambitious activities increase your symptoms? (recreation) | | | |
| 9. Because of this problem, are you afraid to leave home wihtout having someone with you? | | | |
| 10. Because of this problem, are you embarrassed in front of others? | | | |
| 11. Do quick head movements increase your problem? | | | |
| 12. Because of this problem do you avoid heights? | | | |
| 13. Does turning over in bed increase your problem? | | | |
| 14. Because of this problem, is it diffcult for you to do strenuous work? (household, yardwork) | | | |
| 15. Because of this problem, do you avoid driving your car in the daytime? | | | |
| 16. Because of this problem, are you afraid people think you are intoxicated? | | | |
| 17. Because of this problem, is it difficult for you to go for a walk by yourself? | | | |
| 18. Does walking down a sidewalk increase your problem? | | | |
| 19. Because of this problem, is it difficult for you to concentrate? | | | |
| 20. Because of this problem, is it difficult for you to walk around your house in the dark? | | | |
| 21. Because of this problem, are you afraid to stay home alone? | | | |
| 22. Because of this problem, do you feel handicapped? | | | |
| 23. Because of this problem, do you avoid driving your car when it's dark? | | | |
| 24. Has your problem placed stress on your relationships with your family or friends? | | | |
| 25. Because of your problem, are you depressed? | | | |

NAME: _____ Date: _____

HAVE YOU HAD ANY FALLS IN THE LAST 12 MONTHS? YES NO

*If you circled no you are finished with this form.*

*If you circled yes please complete the following:*

How Many Falls in the Past Year Have you Had? _____ Did any falls cause injury? Yes No

*Falls Efficacy Scale:*

**How confident are you with the following:**

**Taking a bath or shower:**

1: Very Confident 2 3 4 5 6 7 8 9 10: Not At All Confident

**Reaching into cabinets or closets:**

1: Very Confident 2 3 4 5 6 7 8 9 10: Not At All Confident

**Walking around the house:**

1: Very Confident 2 3 4 5 6 7 8 9 10: Not At All Confident

**Preparing meals that don't require carrying heavy or hot objects:**

1: Very Confident 2 3 4 5 6 7 8 9 10: Not At All Confident

**Getting in or out of bed:**

1: Very Confident 2 3 4 5 6 7 8 9 10: Not At All Confident

**Answering the door or telephone:**

1: Very Confident 2 3 4 5 6 7 8 9 10: Not At All Confident

**Getting in or out of a chair:**

1: Very Confident 2 3 4 5 6 7 8 9 10: Not At All Confident

**Getting dressed and undressed:**

1: Very Confident 2 3 4 5 6 7 8 9 10: Not At All Confident

**Personal Grooming (like washing your face):**

1: Very Confident 2 3 4 5 6 7 8 9 10: Not At All Confident

**Getting on and off of the toilet:**

1: Very Confident 2 3 4 5 6 7 8 9 10: Not At All Confident

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*For Clinic Use Only:* *For Clinic Use Only:* *For Clinic Use Only:*

BP: _____ Arm: L R

Position: Sitting Other: _____ Administered by (initials): _____

Height: _____ Weight: _____ Wong-Baker Score: _____

Past pointing: norm mild mod extreme SLS: (L) pos neg (R) pos neg ROM: (L) pos neg (R) pos neg

# Wallace Physical Therapy
## Current Medications

This is a medicare required 'Quality Reporting" measure. 'Adverse Drug Events' ( ADEs ) prove to be more fatal in outpatient settings (1 of 131 outpatient deaths). (Nassaralla et al., 2007). The number of physician office visits to treat ADEs increased from 2.9 million in1995 to 4.3 million in 2001.
This measure is meant to encourage communication between patients and providers of the patient's medication regime with consideration of it's impact upon health, impairments,activity limitations, and participation restrictions.

**Name:** _____ **Date:** _____

**Medications:** Prescription, Over the Counter, Vitamins & Minerals, Herbals & Supplements
**Dose:** Mg. Frequency: # of times per day, or 'as needs'. Route: **O=Oral, IN=Inject, IH=Inhale**

| Drug Name | Dose | Frequency | Route |
|---|---|---|---|
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Medication Allergies / Sensitivities: _____

_____

**Patient Signature:** _____ Date: _____ Init._____ Date_____
Therapist: _____ Date: _____ Init: _____ Date: _____
Discussion:_____

_____

_____

5501 N. Oracle Rd. Suite 101 Tucson, AZ. 85704 (520) 408-0547 Fax (520) 408-8145

# Wallace Physical Therapy

ORTHOPEDIC-INDUSTRIAL-SPORTS-PERSONAL-INJURY

## MEDICAL HISTORY

NAME:_____ DATE:_____

Primary Care Physician:_____

Referring Physician:_____

Have you had surgeries for this injury? Y N

Type of Surgery:_____ Date of Surgery:_____

Have you had any of the following intervention for this injury?

| | | |
|---|---|---|
| Urgent Care_____ | MRI_____ | Physical Therapy_____ |
| X-rays_____ | EMG_____ | Occupational Therapy_____ |
| CT Scan_____ | Chiropractor_____ | Orthopedist_____ |
| Neurologist_____ | Other____ | |

Do you or have you ever been treated for any of the following conditions:

| | | |
|---|---|---|
| Anemia_____ | GERD_____ | Multiple Sclerosis_____ |
| Allergies_____ | Headaches_____ | Osteoporosis_____ |
| Arthritis_____ | Head Injury_____ | Pace Maker_____ |
| Asthma/Lung Problems____ | Hearing Problems_____ | Parkinson's Disease_____ |
| Back Injury_____ | Heart Attack_____ | Sleep Apnea_____ |
| Blood Clots_____ | Heart Disease_____ | Sleeping Disorder_____ |
| Blood Pressure High/Low____ | Heart Surgey_____ | Stroke/TIA_____ |
| Cancer_____ | Hepatitis___ | Swelling of Limbs_____ |
| CHF_____ | Hernia_____ | Tinnitus (ringing in ears)_____ |
| Circulation_____ | HIV/AIDS_____ | Thyroid issues_____ |
| Depression_____ | Hysterectomy_____ | Urinary Incontinence____ |
| Diabetes(Type)_____ | Joint Replacement_____ | Ulcers_____ |
| Dizziness_____ | Loss Balance_____ | Vision Problems_____ |
| Epilepsy/Seizures_____ | Neck Pain_____ | Weakness_____ |
| Fractures_____ | Numbness/Tingling____ | Weight Loss_____ |
| Fibromyalgia_____ | | |

Are you pregnant? Y / N Do you smoke? Y / N

Other :_____

Signature: _____ DATE: _____

*Who may we thank for referring you to us?*_____

*Please add me to your newsletter mailing list:* Y/N

I have reviewed the patient's medical history with him/her. Y/N

Therapist Signature: _____