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 Billing Procedure
Billing Service Is: Assurance Medical Management
Account Manager Is: Bambi Anaya Contact Her At 318-3500
if you have any questions or concerns.

All other insurance patients:

You must first meet calendar year deductible before your insurance company will pay. Your claim will be filed to your insurance. Your insurance has 45 days to pay the claim unless they are asking for medical review. If your insurance is requesting further information from you please contact the billing service listed above and let them know. If you reach maximum benefits for physical therapy, the remaining balance is your responsibility and you will receive a statement. If you have a secondary, they will be billed when the primary pays. If you do not have a secondary, you will receive the bill for the remainder.

Self Pay Patients:

Payment is due at the time of service unless you have a signed agreement with Mr. Robert Wallace.

Workers Compensation Patients:

We need all employer information, the claim number, date of injury, and insurance company information. If we have received incomplete information, or if the insurance company denies the claim, you will be responsible for the bill. We will keep your employer and employer's insurance informed on your treatment and attendance.

Also when billing your medical insurance, we are given a quote of benefits not a guarantee of coverage. This will ultimately leave you responsible for the bill if your medical insurance does not pay.

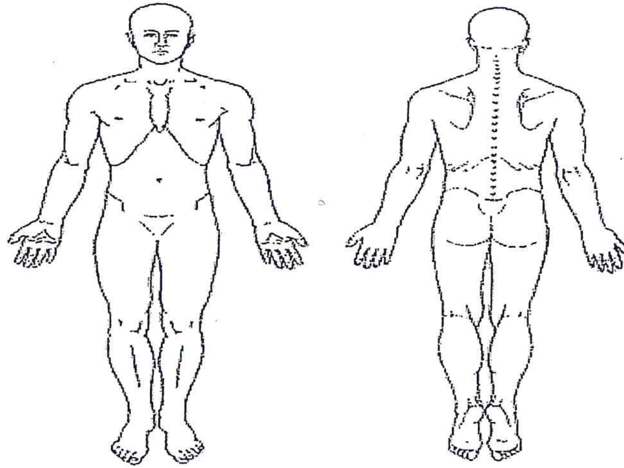
Statements are sent throughout your duration of therapy the balance will change as your insurance company pays. Just because you receive a statement does not mean that is all you owe. The numbers of statements depends on the length of therapy. Statements are sent once a month. When you have received 3 statements and no payments have been received, you will receive a final notice. You have 10 days to respond to the final notice; you may set up payment arrangements. If you do not respond, you will be going to collections. If you set up a payment plan, you need to make the promised payments; if you cannot, please contact the billing service. Once you are in collections it is your responsibility to get in contact with billing service when you receive your final notice.

Signature: ______________________________ Date: ____________________

Pain / Problem Assessment

Name: ________________ Date: ___________________

Please indicate areas where you have pain or problems for which we will be treating you:



Nature of your pain problem? (i.e. sharp, shooting, dull, aching, throbbing, etc.)

____

____

____

Severity of pain – on a scale of 0-10 with 0 being no pain and 10 being severe pain.

Rank Pain at its WORST __________

BEST __________

AVERAGE __________

0 no pain
1-2 very little
3-4 mild
5-6 moderate
7-8 a lot
9-10 excruciating

PAIN IS BEST WHEN I:

Sit_____ Lie Down ______ stand ______ walk _______ other _______

PAIN IS WORST WHEN I:

Sit _____ Lie Down ______ stand ______ walk _______ other _______

How is the pain problem affecting your life? (i.e. hurts to walk etc.)

____

____

____

Signature: ______________________

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: ____