WALTON
PHYSICAL THERAPY AND SPORTS MEDICINE

Physical therapy is typically prescribed twice a week for four to six weeks. The average length of your appointments will be approximately an hour. Wear or bring comfortable clothing, allowing access to the injured area. Please do not forget proper footwear.

Physical therapy is billed by the procedure performed at each visit. It is not billed by the hour. Therefore, charges may vary from visit to visit. An average physical therapy visit may cost between $180.00 to $200.00.

Due to the nature of insurance billing and the number of prescribed visits, you will receive your bill from Walton Physical Therapy once a month. The bill will include a running balance for services processed by your insurance to date. Most insurance companies take 30 days to process claims. Please note you may receive your first bill after you have completed therapy.

Walton Physical Therapy's Cancellation Policy requires that at least 12 hours advance notice will be given on all cancelled appointments. By signing below you acknowledge that you have read and understand the information outlined above.

X_____ _____

Signature of Patient or Parent if Minor Date

We are happy to have you as our patient and look forward to working with you.

We truly value your recovery and experience at Walton Physical Therapy.

Thank you for filling out our paperwork. We understand your time is valuable.

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In order to serve you properly, we need the following information. Please print. All information will be confidential.

Patient Information

Patient Name _____ Date of Birth _____ Gender: _____

Address _____ City _____ State _____ Zip _____

Primary Phone _____ Secondary Phone _____ Email _____

Opt for Appointment Text Reminders ☐

Employer _____ Work Phone _____

Emergency Contact _____ Phone _____ Relationship _____

How did you hear about WPTSM? Who referred you to our office? _____

***Your benefits may be affected by previous treatment elsewhere (visit limits, authorizations, etc.) Please note the number of physical therapy visits you've had this year and the clinic/facility:** _____

Parent / Guardian Information (If patient is under 18, please complete the following)

Name of Person Responsible for this Account _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Relationship to Patient _____ Employer _____ Work Phone _____

Primary Phone _____ Secondary Phone _____

Primary Insurance Information (Please inform us if you have a secondary insurance)

Does not need to be completed if a card was presented at front desk for scanning

Primary Insurance _____ Policy/ ID # _____ Group # _____

Policy Holder Full Name _____ Policy Holder DOB _____ Relation to Patient _____

Insurance Address _____ Insurance Phone _____

Work Injury / Accident Information

Accident Date _____ Claim # _____ Accident Insurance Name _____

Adjuster Name _____ Adjuster Phone _____

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Chief Complaint (problem for which you are receiving treatment): _____

Have you recently experienced any of the following? Check all that apply

- ☐ Urinary or bowel problems
- ☐ Nausea/Vomiting
- ☐ Dizziness/lightheadedness
- ☐ Difficulty maintaining balance
- ☐ Fever/chills/sweats
- ☐ Weight gain/loss
- ☐ Shortness of breath
- ☐ Headaches
- ☐ Changes in appetite
- ☐ Pain at night
- ☐ Weakness/fatigue
- ☐ Difficulty Swallowing
- ☐ Sexual Difficulty
- ☐ Prostate Problems (male)
- ☐ Menstruation problems (female)

Have you ever been diagnosed with the following conditions? Check all that apply

- ☐ Cancer (type) _____
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Asthma
- ☐ Pacemaker
- ☐ Osteoporosis
- ☐ Chemical dependency
- ☐ Rheumatoid arthritis
- ☐ Stroke
- ☐ Depression
- ☐ Anemia
- ☐ Lung problems
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Multiple Sclerosis
- ☐ Kidney/Liver problems
- ☐ Stomach Ulcers
- ☐ Epilepsy
- ☐ Parkinson's disease
- ☐ Allergies _____
- ☐ Other _____

Please list any current medications: _____

Are you currently taking any blood thinning or anti-coagulant medications? YES/NO
Do you smoke? YES/NO
For Women: Are you currently pregnant or planning on becoming pregnant? YES/NO

Please list surgeries or other current conditions requiring hospitalization in the last 12 months.

_____

What clinical test have you had related to your current condition? (x-ray, MRI, CT, etc.)

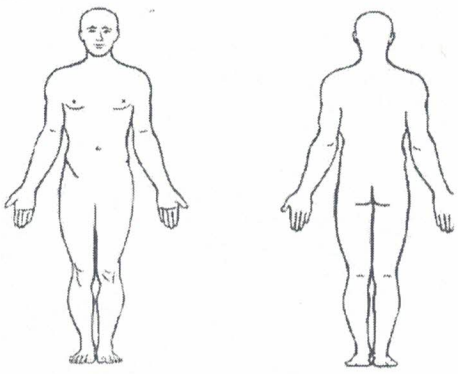
_____

What activities are you unable to perform due to your condition? (ex. reaching overhead, stairs, running, sport)

_____

What is your current pain level?
0 1 2 3 4 5 6 7 8 9 10

Body Chart:
Please mark the location of your pain.



Consent for Care and Treatment
I, the undersigned, do herby agree and give my consent fort Walton Physical Therapy to furnish medical care and treatment to me (or my child) considered necessary and proper in diagnosing or treating my (or my child's) condition.

X_____ _____
Signature of Patient (Parent if patient is a minor) Date

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

(To Be Retained By Medical Provider)

I understand that **Walton Physical Therapy** (referred to below as "the clinic") will use and disclose **health information** about me in the course of providing physical therapy care to me.

I understand that my **health information** may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar health-related information.

I understand that the clinic is permitted to **use and disclose** my health information in order to:

* make decisions about and plan for my care and treatment;
* refer to/or consult and coordinate with other health care providers in the course of my treatment;
* determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
* perform various office, administrative and business functions that support the clinic's ability to provide me with appropriate care and arrange for payment.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request and that a copy or a summary of the most current version of the clinic's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

By signing below, I agree that I have received or been offered a copy of this clinic's Notice of Privacy Practices.

_____ _____

(Patient) **Date:**

-OR-

_____ _____

(Patient representative) **Date:**

Description of Representative's Authority: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify) _____

Warranty and Release
(Must be signed by Parent or Guardian)

"The undersigned understands and agrees that he/she, while attending said Bay Club and using the facilities and equipment therein, does so at his or her own risk. Bay Club shall not be liable for any damages arising from personal injuries sustained in, on, or about the premises of said athletic club. The undersigned assumes full responsibility for any injuries or damages which may occur to self, in, on, or about the premises of said facility, and does hereby fully and forever release and discharge the athletic club, owners, and employees, from any action or cause of action present or future, whether the same be known or unknown, anticipated or unanticipated, resulting from or arising out of the use of said Bay Club or the facilities and equipment thereof."

Signature of Patient:_____

Signature of Parent or Guardian:_____
(If patient is under 18 years old)