WellWorks

PATIENT INFORMATION			EMAIL ADDRESS:_____
First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -	Spouse:	
Chose Clinic Because/ Referred to Clinic By ☐ Dr.:		☐ Insurance Plan ☐ Family ☐ Friend	
☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:			

WORK INFORMATION		
Employer:	Work Phone ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION	
Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)	
Primary Insurance Name:	
Subscriber's Name (If different):	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	
Name of Secondary Insurance:	
Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	

AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)			
Insurance Name: ☐ Auto :		☐ Labor & Industries:	
Adjuster/Claim Manager:		Phone:	Ext.:
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

ATTORNEY INFORMATION			
Name:	Law Firm:	Phone: ( ) -	
Address	City	State:	Zip:

IN CASE OF EMERGENCY		
Name of Local Friend or Relative (Not Living at Same Address):		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to Wellworks Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Wellworks Physical Therapy to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

WellWorks

PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Myocardial Infarction	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker	☐	☐

MUSCLE CONDITION	YES	NO
Carpal Tunnel R/L	☐	☐
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity	☐	☐
Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐

Other: _____

_____

_____

_____

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day ____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week ____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week ____
☐ 5+ x Week	☐ Heavy Labor			

What types of exercise do you perform? : _____

What things cause stress in your life? :

Are you taking any seizure medication? ☐YES ☐NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐YES ☐NO If yes list name: _____

List all medications you are currently taking: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? ☐ YES ☐ NO What week?: _____

Have you had any injuries related to work? ☐ YES ☐ NO If yes list body part and date.: _____

Have you had any Auto Accidents ☐ YES ☐ NO If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? ☐ YES ☐ NO Where:

_____ _____

Signature of Patient, Parent, Guardian, Personal Representative Date

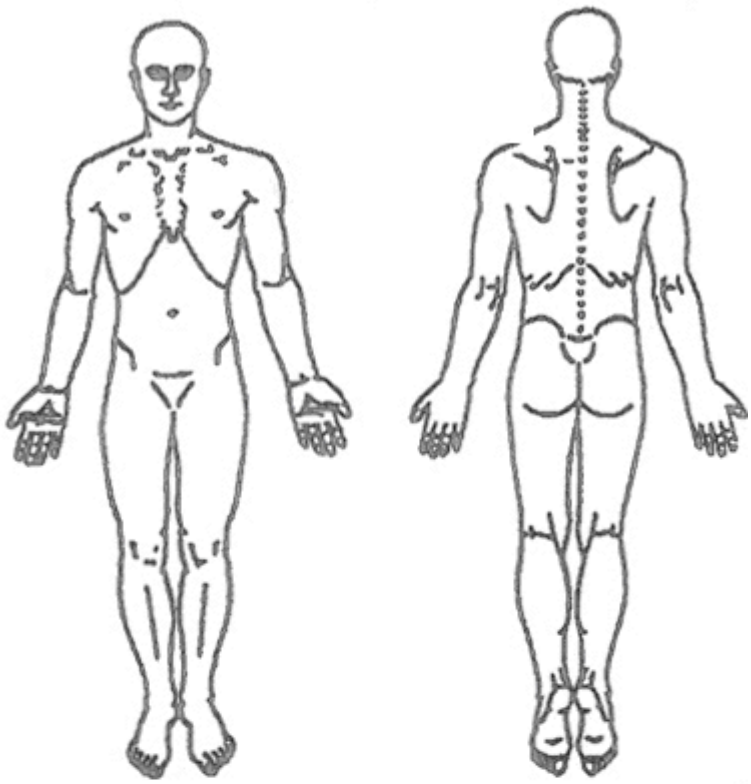
Pain and Symptom Status Report

Name: _____ **Date:** _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing

Ache	Burning	Numbness
MMM	— — —	O O O O
M	— —	O O O

Pins and Needles	Stabbing	Other
o o o o o o o o o o	/ / / / / /	x x x x
o o o o o o o o	/ / / /	x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____
Date First Symptom of your problem occurred on. _____

2nd Complaint _____

3rd Complaint: _____

Please circle on the scale below to indicate your CURRENT level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it gets.**

Please circle on the scale below to indicate your AVERAGE level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it gets.**

Please circle on the scale below to indicate your WORST level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it gets.**

Additional Comments _____

WellWorks

Spinal/Joint Mobilization Informed Consent

The information below is to inform you regarding a treatment technique commonly performed in physical therapy. If you agree to this treatment, please sign your name and date at the bottom of this form. WellWorks Physical Therapy thanks you for your cooperation.

1. Question: What is mobilization?
   Answer: It is a hands on procedure carried out to correct soft tissue or boney problems.

2. Spinal or joint mobilization can produce the following benefits:
   a. Correct the position of a spinal or joint segment, thus increasing joint mobility.
   b. Decrease pain symptoms.

3. Spinal or joint mobilization cannot be done if a patient:
   a. Is taking anticoagulant medication.
   b. Has a broken bone in the area of a mobilization that is not healed (6 weeks).

4. Which health care professionals can do mobilization procedures?
   a. Chiropractors
   b. Orthopedic Physical Therapists
   c. Doctors of Osteopathy and Medical Doctors

5. What are other appropriate treatment options besides mobilization?
   a. Modalities including heat, ultrasound and electrical stimulation.
   b. Soft tissue mobilization and Myofascial release techniques.
   c. Exercises.

I agree to this treatment.

_____

Patients Signature Therapist Signature and Date

WellWorks

TO OUR PATIENTS

- **All insurance co-payments are due at the time of service.**
- **If you have a large deductible to meet, a payment of at least $75.00 will be due at each visit until the deductible has been met.**
- **It is the patient's responsibility to keep in contact with their insurance company in order to track whether their insurance deductible has been met for the year.**

_____

Patient Signature

_____

Witness

WellWorks

Financial Policy

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals; we need your assistance and your understanding of our payment policy.

It is important that you understand that:

1. Your insurance is a contract between you, your employer if applicable and the insurance company. We are not a party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they limit or do not cover.

Payment for services is due at the time services are rendered unless payment agreements exist with your insurance carrier or personal arrangements have been approved in advance by our staff. We will accept cash or checks. Patients should expect to keep their accounts current while waiting for their insurance company to reimburse them. We will be happy to assist you in processing your insurance claim form for your reimbursement. Any such request must be accompanied by complete insurance billing information. Please be advised that there will be a $40.00 service charge added to your account for returned checks.

If you are unable to keep your appointment, please call in advance so that someone else may see the therapist in the time, which has been reserved for you. There will be a $50.00 charge added to your account for all no show appointments and for les than 12 hours cancellation notice. Should the account be referred to collections, the undersigned shall pay reasonable collections expenses including attorney's fees.

As physical therapy providers, our relationship is with you. We understand that temporary financial problems may affect timely payment to your account. If such problems do arise, we encourage you to contact us for assistance in the management of your account.

If you have any questions regarding the above information or regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

The undersigned certifies that he/she has been informed and has red the foregoing and is the patient, patient's guardian, or is duly authorized by that patient as patients general agent and that he/she accepts the terms contained in this financial policy.

_____ _____

Patient Signature Date

WellWorks

Patient Consent to Treat

I hereby authorize and grant permission to ***WellWorks Physical Therapy***, to carry out any assessment and examination, procedure sand treatments as may be necessary to access and treat my condition or injury.

The above-named physical therapist group and staff has agreed to provide me with understandable information on:

- My diagnosis as known
- The treatment being suggested
- Significant risks, benefits or treatment, and possible alternative to this treatment
- Reasonable additional procedures which may be necessary
- The potential risk(s) of foregoing suggested care

I hereby authorize and grant permission to ***WellWorks Physical Therapy*** to release information regarding my condition and my ability to return to normal activity or work to my □Insurance company, □ Employer, □ Lawyer or their representative (please check those that apply). I also hereby authorize and grant PRN a billing and collections company/representative for ***WellWorks Physical Therapy*** the permission to release information regarding my condition to my, □ Insurance Company, □ Employer, □ Lawyer or their representative (please check all the apply).

I, _____understand the conditions and information as verbally provided and voluntarily give my consent to the above authorizations.

_____

Signature Date Witnessed by

WellWorks

No Shows and Cancellations

Reminder…

We would like to remind you of WellWorks Physical Therapy's policy on late cancellations (cancellations without at least 12 hours notice) and "no shows" (missed appointments without a call to cancel or reschedule).

We may charge a fee of $50.00 for any appointment that is cancelled without at least 12 hours notice and for any no shows. ***This fee is due directly from the patient and is payable at the time of the next scheduled appointment.*** As a matter of policy, your referring physician and claims adjuster if applicable, are notified each time an appointment is missed for any reason.

Reminder regarding discharge due to missed appointments…..

It is WellWorks Physical Therapy's policy that after a patient no shows or cancels their appointments for three (3) consecutive scheduled visits they are automatically discharged from the program and must return to their physician to obtain a new prescription or referral for physical therapy before resuming care. Physician, Adjuster and Case Manager will be notified as well.

Out of consideration for staff and fellow patients, as well as consistency in your rehabilitation, please contact our office immediately if you are unable to attend your scheduled visits.

Thank you…

_____ _____

Patients Signature Date

WellWorks

3.5.1C Patient Privacy Notice Acknowlegement

I have read and understand the HIPPA Protected Health Information Privacy Notice 3.5.1A. I understand that upon request a copy of the complete notice will be provided to me.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date