Wellworks
Physical Therapy and Rehabilitation Inc.
500 W. Glenoaks Blvd. Glendale CA 91202 • Tel: 747-272-0027 • Fax: 7474-272-0041

Date _____ Social Security Number _____ - _____ - _____
Fecha *Seguro Social*

History Have you ever been a patient at Wellworks Physical Therapy and Rehabilitation Inc.? Y N
Historia Ha sido alguna vez paciente de Wellworks Physical Therapy and Rehabilitation, Inc.? S N

IS THIS INJURY WORK RELATED? _____ AUTO ACCIDENT? _____

Patient Information/Informacion Del Paciente

Legal Name (Last, First, Middle) _____
Nombre Legal (Apellido, Primer Nombre)

Street Address _____ City _____ State _____ Zip _____
Dirección (No P.O. Box) *Ciudad* *Estado* *Zip*

Home Phone (_____)_____ Cell Phone (_____)_____ Date of Birth _____ Sex M F
Teléfono *Teléfono celular* *Fecha de Nacimiento* *Sexo M F*

E-mail Address: _____

In case of emergency who should be notified? _____ Phone Number (____) _____
En caso de emergencia a quién notificamos *Teléfono*

***Referring Physician _____ Preferred Language: _____
Médico referente *Idioma Preferido*

Insurance Carrier: _____
Compañía de seguros

Workers Compensation Only

Employer _____
Empleo

Employer Phone (_____)_____ Your Occupation _____
Teléfono de Empleo *Ocupación*

Privacy Practices Acknowledgement/ Reconocimiento de la Práctica de Privacidad

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.
He recibido el Aviso de prácticas de privacidad y se me ha brindado la oportunidad de revisarlo.

Signature: _____ Date: _____
Firma *Fecha*

Wellworks Physical Therapy and Rehabilitations, Inc does not and shall not discriminate on the basis of race, color, religion, gender, gender expression, age, national origin, disability, marital status, sexual orientation, or military status, in any of its activities or operations.
Wellworks Physical Therapy and Rehabilitations, Inc no discrimina y no discriminará por motivos de raza, color, religión, género, expresión de género, edad, origen nacional, discapacidad, estado civil, orientación sexual o estado militar, en ninguna de sus actividades u operaciones.

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Name: _____ Date: _____ Date of Injury: _____

To help us with your therapy, please indicate if any of these conditions apply to you:

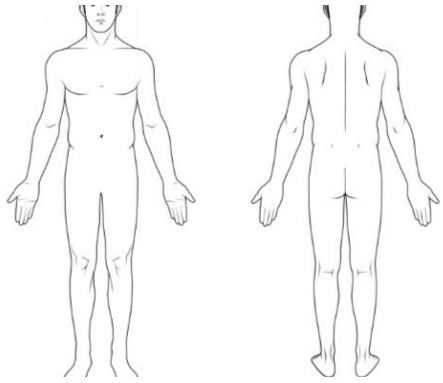
	Yes	No		Yes	No
• High Blood Pressure	__	__	• Pacemaker	__	__
• Diabetes	__	__	• Chest Pain	__	__
• Arthritis	__	__	• Smoking	__	__
• Osteoporosis	__	__	• Shortness of Breath	__	__
• Headaches	__	__	• Respiratory Disease	__	__
• Dizziness	__	__	• Hearing Loss	__	__
• Stroke	__	__	• Impaired Vision	__	__
• Seizures	__	__	• Anxiety Disorder	__	__
• Cancer	__	__	• Depression	__	__
• Hepatitis/HIV Positive/TB	__	__	• Height	_____	
• Pregnant	__	__	• Weight	_____	

Other Conditions (include allergies): _____

Past Medical History (include dates of surgeries, significant injuries, and any metal implants):_____

_____

Medications:_____



Your pain is: ___Constant ___Intermittent

On a scale of 0-10 (0 = no pain, 10 = worst imaginable pain), your pain is currently a ____ and ranges from ____ to ____.

Please indicate the location of your symptoms on the left:
O = circle areas with pain
X = mark an X where there is most pain
/// = shade areas with numbness, tingling, or burning

Sports & Activities (bowling, golf, jogging, etc): _____

Goals: _____

Therapist review signature:_____

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Cancellation and No-Show Policy

We strive to provide our patients with the highest quality of care and service. We are committed to your wellbeing—and the restoration of your physical abilities is something that everyone in our clinic takes seriously.
Because we care very much about you, we emphasize the importance of your own commitment to therapy. We know from experience that this is essential for your recovery.

Your adherence to the recommended number of treatments is a vital component of your progress. Thus we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep **all** your appointments and suggest that you write down the time of your visits so that you do not forget.

With the exception of serious emergencies, it is expected that you will keep all your appointments. If you need to re-schedule an appointment, we require 24 hours notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day. You must leave a voicemail if you are unable to call during business hours.

There is a $35 charge for a no-show or cancellation without 24-hour notice. The charge will not be covered by your insurance, but will have to be paid by you personally. We require a credit card number on file to reserve your next appointment, and we will charge your credit card for any future cancellations without proper notice.

If you are late for your appointment, we will try to accommodate you. However, you may not receive full treatment as scheduled.

For Worker's Compensation and Personal Injury patients, we are required to forward documentation of any missed appointments to your case manager and primary physician. This could jeopardize your claim.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and to inform your physician that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.
I have read and understand this policy:_____

Patient Signature

Date:_____

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TREATMENT AND FINANCIAL POLICIES

Thank you for entrusting Wellworks Physical Therapy and Rehabilitation Inc. with your treatment. We operate under the following policies:

Release of Medical Record: In order to facilitate your treatment, you request that all of your medical records relevant to treatment be released to Wellworks Physical Therapy and Rehabilitation, Inc. A copy of this release shall be considered to be as valid as the original. We may use and disclose medical information about you to provide you with medical treatment or services, for payment purposes, for our health care operations. You have been given a copy of our privacy notice. You also have the right to request restrictions on how information about you may be used and disclosed for treatment, payment, and health care operations. This release shall be in effect until revoked.

Consent for Care: You understand that your therapists will discuss with you your diagnoses, treatments, risks, benefits and reasonable expectations for desired results. You are expected to ask any questions you may have regarding the information, so you will have an understanding of the information provided. You hereby give your consent to the staff of Wellworks Physical Therapy and Rehabilitation, Inc. to provide therapy care and services prescribed by your physician, both verbally and written, and to exercise professional judgment regarding any additional care and services that may be necessary. You are aware that therapy may result in one or all of the following: increased pain, swelling, redness, burning sensations, or wound bleeding.

Billing and Insurance: Notify our office as soon as you have any change in insurance coverage. If you fail to give our office your current insurance coverage information, you will be responsible for your bill.

_____ Medicare Insurance: We accept Medicare assignment and will bill Medicare for you. If you have Medicare as your only insurance coverage, you are responsible for the 20% co-payment as well as any deductible. By law, you will be billed for any co-payment or deductible after we receive the Medicare Explanation of Benefits.

_____ Workers Compensation Insurance: We will request authorization from your workers compensation insurance carrier on your behalf. You agree that Wellworks Physical Therapy and Rehabilitation, Inc. may release your medical record to your insurance company for billing purposes. We are also obligated to inform your insurance carrier if appointments are not kept or compliance with your program is not met.

_____ Cash/ Self Payment: Services will be paid upfront at the following rates: $110 for evaluation and treatment, $90 for 1 hour treatment, $60 for 30 minute treatment. You have not provided our company with your insurance information and we will not subnit claims on your behalf. You understand that if you attempt to submit for reimbursement yourself your claim may be denied.

_____ PPO/Other Insurance Plan: Our office will, as a courtesy to you, contact your insurance company to request information regarding your deductible, co-payment, and the terms of coverage for our services. We will inform you of their quote to us but it is not a guarantee of their cooperation or payment. We encourage you to call your insurance company periodically to check for your coverage
and changes in your benefits.

_____Per your insurance quote: your benefits are as follows: Patient Deductible is $ _____ met $_____ Max visits allowed _____ used: _____ Co-payment: $ _____or Co-insurance _____%

Payment Policy: It is patient's sole responsibility to pay for services rendered. We are billing and collecting from your insurance as a courtesy to you. Your insurance policy is a contract between you and your insurance carrier and Wellworks Physical Therapy and Rehabilitation, Inc. is not a party to that contract. If your insurance carrier does not remit payment within 45 days, the patient is responsible for the outstanding balance, including co-payments, deductibles and any percentage that insurance does not cover. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance. We reserve the right to charge interest on balances outstanding more than 45 days from billing, up to .4% per month, but not in excess of the maximum interest allowed by law. Our company policy is to collect all co-payments at the time of check in. A patient statement will be sent if a patient balance should occur after insurance payment. There is a $25.00 fee for returned checks.

I understand if I have an unpaid balance to Wellworks Physical Therapy and Rehabilitation, Inc. and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of the fee of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable collection and attorney's fees incurred during collection efforts. In order for Wellworks Physical Therapy and Rehabilitation, Inc.or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Wellworks Physical Therapy and Rehabilitation, Inc. and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

Please sign below, indicating that you have received a copy of this notice and you have read, understand and agree to the
terms set forth. By your signature, you further agree to final and binding arbitration for any and all claims, disputes or controversies arising between you and Wellworks Physical Therapy and Rehabilitation, Inc., whether contractual, statutory or common law. You additionally agree to waive your rights to a jury trial and to utilize the services of, and to arbitrate under the then rules promulgated by, the American Arbitration Association.

_____ _____ _____
Signature of Patient or Responsible Party Print Name Date