WALK&TALK
THERAPY SERVICES

Welcome to Walk & Talk Therapy Services

We are pleased that you have chosen our group for your rehabilitation needs. Our dedicated team of physical and speech therapists are here to help you in your recovery, and will be working closely with you to help you reach the goals you and your physician have set.

If you have any questions or we can be of any further help, please feel free to speak to a staff member who will direct your inquiries. This packet will provide you with the phone numbers and people to contact to set up your schedule and keep you informed.

We wish you continued success in your recovery.

Our email is: *walkandtalkts@gmail.com*

Our telephone number is: *732.810.2633*

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I authorize Walk & Talk Therapy Services (physical therapists, speech therapists and/or doctor's thereof) to examine me, and do whatever is deemed necessary in accordance with the state statutes of the care and management of my condition.

I hereby authorize the release of the health evaluation, examination and treatment records and the prognosis to my phyisican, employer, attorney or insurance company.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and credited to the account on receipt. However, I clearly understand and agree that all services rendered will be immediately due and payable.

_____ _____

Signature Date

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Date:_____

___New Patient
___Info Change

PATIENT INFORMATION:
(This information is in regard to the person seeing the therapist)

Patient Name:_____
Address:_____
City,State & Zip:_____
Date of Birth_____ Age:_____ Sex:___
Marital Status:_____
Spouse Name:_____
Social Security Number:_____
Home Phone:_____
Work Phone:_____
If Worker's Comp, please state where injury took Place, full address and phone number.
Employer:_____
Employer's Address:_____
_____
Employer's Phone #:_____
Referring Physician:_____
Phone:_____
Family Physician:_____
Phone:_____
Allergies:_____

RESPONSIBLE PARTY INFORMATION:
(If anyone other than patient is responsible for payment we need the following:

Responsible Party Name:_____
Address:_____
City,State & Zip:_____
Home Phone:_____
Work Phone:_____
Employer:_____
Employer's Address:_____
Social Security Number:_____
Date of Birth:_____

NEAREST RELATIVE INFORMATION:
(This information will be used when we are unable to contact the patient. For example, if your therapist is called out for an emergeny and your appointment must be cancelled)
Name:_____
Address:_____
City,State & Zip:_____
Home Phone:_____
Work Phone:_____

INSURANCE INFORMATION

PLEASE CHECK ONE AND COMPLETE INFORMATION BELOW:
Private Insurance (Group)___ Worker's Comp:____ Auto Accident:___ Individual___ Other____
Is this visit due to injury on the job? Y/N Date of Injury:_____ Auto Accident date of Injury_____
Insurance Company Name:_____ Phone:_____ WC Adjuster:_____
Address:_____ City:_____State:_____ Zip:_____
Policy Number:_____ Group Number:_____
Policy Holder:_____
Patient's relationship to policy holder: Self____ Spouse____ Child____ Other____
Insurance Authorization #:_____

SECONDARY INSURANCE:
Insurance Company Name:_____ Phone:_____ WC Adjuster:_____
Address:_____ City:_____State:_____ Zip:_____
Policy Number:_____ Group Number:_____
Policy Holder:_____
Patient's relationship to policy holder: Self____ Spouse____ Child____ Other____

Have you at this time engaged the services of an attorney in connection with your present illness? __Yes__No
If "Yes" who is the attorney:_____Phone Number:_____
If "No" do you anticipate retaining an attorney? ___Yes ___No

PROVIDER NOTICE TO BENEFICIARY

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Although our office verifies the insurance coverage of each patient prior to treatment, there may be some instances in which an insurance carrier will not cover certain charges per the terms of the patient/care contract. Because we are unable to anticipate exactly what type of services will be provided prior to your visit with your therapist, you may receive services which are not covered by your insurance carrier.

Beneficiary's Acknowledgment and Agreement to Pay

I have been notified by my provider of services that if my insurance carrier denies payment for any services not covered in my patient/carrier contract, I agree to be personally and fully responsible for payment.

_____ _____

Beneficiary's Signature Date:

_____ _____

Provider's Signature (or representative) Date:

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HISTORY OF PRESENT ILLNESS

Reason for your Visit:

_____

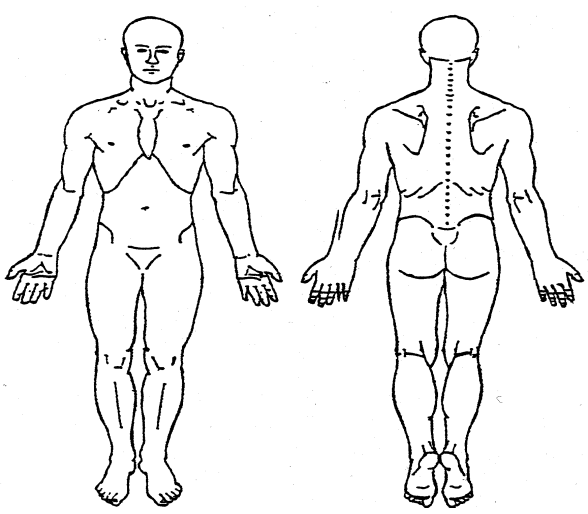
_____

Please describe your current symptoms:

_____

_____

Draw your pain



Key:

∴ tingling/numbness → shooting

××× sharp ≈ burning

/// dull ache ooo throbbing

Write a number that corresponds to the severity of your pain on a scale from 0 – 10. _____.
(0 means no pain, 10 is the worst pain imaginable)

Describe the character of your pain (check all that apply):

[?] Continuous, steady, constant [?] Superficial
[?] Rhythmic, periodic, intermittent [?] Deep
[?] Brief, momentary, transient (Frequency _____, duration _____)

Are your symptoms getting (circle one): Worse The Same Improving

What makes your pain worse? _____

What makes your pain less? _____

Have you had: Physical therapy for this injury before now? [?] yes [?] no

E.R. [?] Yes [?] No Epidural? [?] Yes [?] No Cortisone shot? [?] Yes [?] No
X-rays? [?] Yes [?] No CT scan? [?] Yes [?] No MRI? [?] Yes [?] No
EMG? [?] Yes [?] No

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SOCIAL HISTORY

What is your ethnicity? Caucasian___ African-American___ Hispanic___ Asian___ Pacific Islander___ Other_____
Do you drink alcohol? ☐ Yes ☐ No How much? _____
Do you use recreational drugs? ☐ Yes ☐ No What type / how much _____
Do you now (as of 1 month ago) smoke cigarettes? ☐ Yes ☐ No How many years have you smoked? _____
Are you taking any medication? Please list. _____
Any medication allergies? _____

MEDICAL HISTORY

Have you or any immediate family member ever been told you have

	Self	Family		Self	Family
Cancer ?	Yes...No	Yes.....No	Diabetes ?	Yes ..No	Yes.....No
High blood pressure ?	Yes ..No	Yes.....No	Heart disease ?	Yes...No	Yes.....No
Angina/chest pain ?	.Yes...No	Yes.....No	Stroke ?	Yes...No	Yes.....No
Osteoporosis ?	Yes ..No	Yes....No	Osteoarthritis ?	Yes...No	Yes.....No
Rheumatoid arthritis ?	Yes...No	Yes.....No			

In the past 3 months have you had or do you experience:

A change in your health ? Yes.....No	Nausea/Vomiting ? Yes.....No
Fever/chills/sweats ? Yes.....No	Unexplained weight change ? Yes.....No
Numbness or tingling ? Yes.....No	Changes in appetite ? Yes.....No
Difficulty swallowing ? Yes.....No	Changes in bowel or bladder function ? Yes.....No
Shortness of breath ? Yes ....No	Dizziness ? Yes.....No
Upper respiratory infection ? Yes....No	Urinary tract infection ? Yes....No

Do you have a history of:

Allergies/Asthma ? Yes.....No	Headaches ? Yes.....No
Bronchitis ? Yes.....No	Kidney disease ? Yes.....No
Rheumatic fever ? Yes.....No	Ulcers ? Yes.....No
Sexually transmitted disease ? Yes.....No	Seizures ? Yes.....No

Are you currently:

Pregnant ? Yes.....No	Depressed ? Yes.....No
Under Stress ? Yes.....No	

General Instructions: Check YES or NO for the following. If YES, please EXPLAIN:

☐ Yes ☐ No Are you partially disabled in any way?_____
☐ Yes ☐ No Have you ever received Workers' compensation benefits or lost time for a job-related injury? _____
☐ Yes ☐ No Have you ever lost time from work due to illness during the past 3 years: If so, give appropriate number of days and explain. _____
☐ Yes ☐ No Have you ever had any surgical operation, or been advised to have one? _____

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WORK REQUIREMENTS

Please take time to help us understand your job. Prior to your injury, did you do any of the following?

- What is your job? _____
- How long have you worked in your present job? _____
- Lift from the floor ☐ Yes ☐ No Max wt._____
- Lift above the shoulders ☐ Yes ☐ No Max wt._____
- Carry weight ☐ Yes ☐ No Max wt._____
- Push/pull ☐ Yes ☐ No Max wt._____
- Climb: ☐ Yes ☐ No
- Squat: ☐ Yes ☐ No
- Stand most of the day ☐ Yes ☐ No
- Walk most of the day: ☐ Yes ☐ No
- Sit during the day: ☐ Yes ☐ No
- Repetitive strong gripping: ☐ Yes ☐ No
- Repetitive use of finger/forearm (typing): ☐ Yes ☐ No
- Frequent driving ☐ Yes ☐ No
- Any other work requirements we should know about? _____

I agree that the above is true and correct to the best of my knowledge.

Date: _____ Signed: _____

NOTICE OF PRIVACY PRACTICE

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU IS MANAGED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We have summarized our responsibilities and your rights on this first page. For a complete description of our privacy practices, please review this entire notice.

Our Responsibilities:

The Office is required to:

- Maintain the privacy of your health information.
- Provide you with this notice of our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.

Your rights:

As a patient of the Office, you have several rights with regard to your health information, including the following:

- The right to request that we not use or disclose your health information in certain ways
- The right to request to receive communications in an alternative manner or location.
- The right to access and obtain a copy of your health information.
- The right to request an amendment to your health information.
- The right to an accounting of disclosures of your health information.

We reserve the right to change our privacy practices and to make the new provisions effective for all health information we maintain. Should our privacy practices change, we will post the changes on the bulletin board in our Center, as well as on our website. A copy of the revised notice will be available after the effective date of the changes upon request.

We will not use or disclose your health information without your authorization, except as described in this notice.

If you have questions and would like additional information, you may contact the Administrator.

Understanding Your Health Record/Information:
Each time you visit the Center, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care you received.

- Means by which you or a third-party payer can verify that services billed were actually provided.
- A tool in educating health professionals.
- A source of data for medical research
- A source of information for public health officials who oversee the delivery of health care in the United States.
- A source of data for Healthcare Center planning and marketing.
- A toll with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Date: _____ Signed: _____