WORKERS COMPENSATION INFORMATION

Today's Date_______________________________________

PATIENT INFORMATION

Name__________________________________E-mail____Age__________Sex___________
Address ____ City____________________________________State___________Zip__________
Telephone (home) ______________________________ (work)______________________________ Cell________________________________
D.O.B_____________________________SSN____________________________
Worker Compensation Physician: (Who is referring you to Integrity Therapy?____
Employer's Name ____Occupation____
Employers Address ____City__________________________State____________Zip___________
Employers Telephone # ____ Injury verified by____
Emergency Contact Person________________________________Telephone______________________Relationship_______________________

CARRIER INFORMATION

Workers Compensation Carrier ____

Carrier Address ____
Carrier Phone Number____
Adjuster ____
Claim Number ____

INJURY INFORMATION

Date of Injury ____ Time_________________ ☐ AM ☐ PM
Place of Injury ____
Was Accident Reported to Employer? ☐ yes ☐ no Name of person who took accident report _______________________________________
How did accident happen?
____
____
Have you lost time from work? ☐ yes ☐ no How much? __________________
Have you seen another physician for this condition? ☐ yes ☐ no
Doctor's Name ____ ____
Were x-rays taken? ☐ yes ☐ no Other test? ☐ yes ☐ no
If yes, please list test and by whom.____
____
Do you have any previous Workers Compensation Injuries, if yes, please explain
____
____

AUTHORIZATION/GENERAL CONSENT

I hereby assign, transfer, and set over to Integrity Therapy Group all of my rights, title, and interest to my medical reimbursement benefits under my workers compensation policy for physical therapy treatments. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. In consideration of services rendered, I do hereby agree to guarantee payment of all services not covered by workers compensation.. In consideration for other patients receiving physical therapy, I will attempt at least a 24-hour notice if cancellation or re-scheduling is necessary. I understand since this is a worker compensation claim, any cancellations for no-show appointment may be reported to any of the following: Physician, Case worker, Adjustor, Employer.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE GENERAL CONSENT FORM

Patient's Signature____Date______________________________