Worker's Compensation Information

PATIENT INFORMATION

Name ____________ Email ____________ Age______ Sex ______
Address ____________ City ____________ State ______ Zip ______
Telephone: Home ____________ Work ____________ Cell ____________
D.O.B ____________ SSN ____________ Marital Status ____________
Emergency Contact Person ____________ Telephone ____________ Relationship ____________
Claim Number ____________
Do you have a RN Case Manager? ____________ Contact Number ____________
Adjuster's Name ____________ Contact Number ____________
Employer's Name ____________ Occupation ____________
Employer's Address ____________ City ____________ Zip____________

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
If yes, how much time? ____________
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 or no-show appointments will be reported to any of the following: Physician, Case worker, Adjustor, Employer. I also understand that 3 or more no-shows or cancellations with less than 24-hour notice could be reason for discharge due to non-compliance.

I have read and fully understand the above general consent form:

Patient's Signature ____________ Date ____________