Patient Information (Workman's Comp)

First Name:_____ MI: _____ Last Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Birthdate:____/____/____ Day Phone:_____ Evening Phone:_____ Cell Phone:_____

Gender (circle): M / F Social Security #:_____ (Use signing parent's # if patient is minor under 19 yrs)

Email Address:_____ Can we email appointment reminders & information? Yes / No

Emergency Contact:_____ Relationship:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Workman's Comp Carrier Insurance Information

Have you attended Physical Therapy for this problem at another facility? Yes / No

If so, please tell us start date: ____/____/____ and end date: ____/____/____.

Insurance Company Name:_____ Address:_____

City:_____ State:_____ Zip:_____ Phone#:_____

Date of Injury: ____/____/____ Carrier Case#:_____ WCB Case#:_____

Case Manager:_____ Phone#:_____ Fax#:_____

Are you currently working? Yes/No Your Employer at the time of the accident:_____

Employer Address:_____

Secondary Insurance Information: (private insurance if claim is denied)

Insurance Company Name:_____ Address:_____

City:_____ State:_____ Zip:_____ Phone#:_____

ID#:_____ Group#:_____ Name of Insured Person:_____

Relation:_____ Birthdate:____/____/____ Insured Employer:_____

Employer Address:_____

I give my permission to SportsFocus Physical Therapy, PC to Release information to my insurance company. I authorize payment directly to SportsFocus Physical Therapy, PC for treatment I receive.

Signature:_____ Date: ____/____/____
(Signature of Patient or Guardian if patient is under 19)

I agree I am primarily liable for all charges for services rendered by SportsFocus Physical Therapy, PC and agree to pay all amounts not paid by my insurance carrier(s) for any reason. If I am claiming coverage under Compensation laws, I understand I am fully liable if such coverage is subsequently denied. I agree to supply private insurance information in anticipation of such a denial. If I am claiming secondary coverage through an HMO (such as IHA, Com Blue or Univera), I understand I am responsible for obtaining a valid referral prior to treatment if required and that treatment without such a referral will cause me to be personally liable for today's charged as well as future charges.

Signature:_____ Date: ____/____/____
(Signature of Patient or Guardian if patient is under 19)

I have been advised of SportsFocus Physical Therapy's **Notice of Privacy Practices Regarding Patient Health Information.** You may request a copy fo this at any time.

Signature:_____ Date: ____/____/____
(Signature of Patient or Guardian if patient is under 19)

Workman's Compensation

You must be covered by Workman's compensation insurance if you were injured at work or as a result of work –related activity. You are responsible for providing all necessary information such as carrier, carrier address and contact information, date of injury, case number, etc. We will bill worker's compensation as required by law however, occasionally, cases are sometimes decided by a worker's compensation judge to NOT fall under worker's compensation. In this event, you would become liable for our charges. If you have a secondary insurance on which you wish to rely, we must be given that information at the time of your **first** visit. HMO companies often require approvals and have benefits with limited visits. You should also be aware that if you fail to pursue a valid Worker's Compensation claim, your personal insurance will probably not cover physical therapy services and you will be personally responsible for the charges.

There are Medical Treatment Guidelines that guide treatment for injuries involving the low back, shoulder, knee and neck. This limits the length of treatment to 8 weeks for low back, neck and knee injuries and 12 weeks for shoulder injuries. If you are making adequate functional improvement in your rehabilitation and may benefit from additional physical therapy past these guideline recommendations, your **Physician** is required to send a variance form to the insurance carrier, Workman's Compensation Board and your attorney if you have one. We will facilitate the process by sending a progress note to the MD approximately 2 weeks before the end of the guideline limits. Once the MD's office faxes the request, the insurance carrier has 15 days to approve or deny the variance and notify the physician. If they do not respond within that time frame, you are able to continue with PT.

We will not be able to schedule appointments for you after the guideline limits without a variance approval and this may include the time while the variance is pending approval. In lieu of the fact that our office will not be informed of variance approval (only the MD's office is notified), please notify us of a variance approval as soon as possible so that you may continue with your physical therapy without any or at least minimal interruption of service.

Signature:_____ Date: ____/____/____
(Signature of Patient or Guardian if patient is under 19)

Cancellations are required 24 hours in advance. Cancellations and no-shows are recorded and shared with your insurance company and your physician. This may negatively affect your case.

For patients with an excessive number of cancellations and no-shows, we reserve the right to limit them to same day scheduling. This would require a patient to call on the day they could attend PT and they would be limited to those times available for that day.

Signature:_____ Date: ____/____/____
(Signature of Patient or Guardian if patient is under 19)