BodyBalance physical therapy

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WORKERS' COMPENSATION
PATIENT & PAYOR INFORMATION FORM

***All** Patients or Patients' Legal Representative, please complete all Sections*

(1) Patient: (Full Legal Name or as on Insurance Card)

Name: ____
Last First Initial Sr. Jr.

Address:____
Street Apt# City State Zip Code

Phone: (_____) ______-________ (_____) ______-________ (_____) ______-________ (_____) ______-________
Home Mobile Work Emergency

Email: ____

Sex: M F **Birthdate:** _____/_____/______ **S.S #** ______/______/_______

(2) Condition to be treated in Physical Therapy:________________________________

Did this Condition Result in Surgery? No Yes If Yes Date of Surgery ____/____/____

Did this Condition Result from a Work Injury? No Yes If Yes Date of Accident ____/____/____

Have You Had PT Anywhere this Year? No Yes If Yes Where?_______________________
When?_____________How Long?_____________

Have you had Chiropractic services for this condition? No Yes If Yes Where? _______________________
When?_____________How Long?_____________

(3) Payor & Work Status Information:

Employer: ________________________________

Name of Company: ________________________________

Company Contact: ________________________________

Occupation: ________________________________

Employed & Working **Yes** **No**

Employed but Not Working **Yes** **No**

Unemployed: **Yes** **No**

Retired **Yes** **No**

Address: ________________________________
City **State** **Zip Code**

Phone #: ( ) _____-_______ **Fax #: ( )** _____-_______

Insurance Company: ________________________________

Patient ID #: _____________ **Claim #:** _____________

Adjustor's Name: ________________________________

Ins. Co. Name: ________________________________

Claim Address: ________________________________

Address: ________________________________
City **State** **Zip Code**

Physical Address: ________________________________

Address: ________________________________
City **State** **Zip Code**

Phone #: ( ) _____-_______ **Fax #: ( )** _____-______

All Patients or Patients' Legal Representative Please Sign Section 8 on Page 3

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(4) Medical Insurance Information (please provide a copy of Insurance card and complete this section in the event that your Workers' Compensation claim is denied)
Check A or B

A. ____ Patient is the insured

B. ____ Insured is ____ Spouse ____ Parent

Name: ____
Last First Initial Sr./Jr.

Address: ____
Street Apt.# City State Zip Code

Phone: (_____) ______-_________ (_____) ______-_________ (_____) ______-_________ (_____) ______-_________
Home Mobile Work Emergency

Date of Birth: ____/____/____ **S.S. #:** _____-____-_____ **Legal ID#:** __________________________

Policy/Plan #: ______________________________________ **Ins. Ph. #:** ____

Claims Mailing Address: ____
Street City State Zip Code

Employer Name: ____ **Employer Phone # (   )** ______- _______

Address: ____
Street City State Zip Code

(5) Patient's Doctor

Referring Doctor: ____

Primary Doctor: ____

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(6) Payment Authorization: ***(Initials required for all 3 statements)***

__________ **Assignment of Insurance Benefits**

Initials **I authorize that the payment of my insurance benefits be made directly to Body Balance Physical Therapy for any services that are related to my work injury/accident/illness claim.**

__________ **Guarantee of Payment**

Initials **I understand that I will be personally responsible for all amounts due for services billed by Body Balance Physical Therapy to a workers' compensation payer which were subsequently declared by them or my employer to be a non-eligible claim.**

__________ **Certification of Information**

Initials **I certify that the information I have provided Body Balance Physical Therapy for treatment and payment under the Workers' Compensation Program is accurate and Truthful. I will advise Body Balance Physical Therapy Immediately if there is a change of my coverage/claim status.**

(7) Signature/ Date:

____ ____________________

Patient or Legal Representative's Signature **Today's Date**

All Patients or Patients' Legal Representative Please Sign Section 8 on Page 3