



Workman's Compensation

PATIENT INFORMATION

Patient _____

Last Name First Name Middle Initial

Home Address _____

Address City State Zip

Home Phone () - Cell Phone () -

May we leave messages at these phone numbers concerning your appointments/account? YES NO

Date of Injury/Surgery / / Email _____

Date of Birth / / Age Social Sec.# - -

Male Female Marital Status: Married Divorced Single Widowed Separated

Is there an Attorney involved in your case? YES NO

***If yes, Peak Physical Therapy will not hold your account for settlement. You will be required to provide your private health insurance & make timely monthly payments on any unpaid balances.**

Employment Status: Employed Unemployed

Employer Occupation _____

Employer Address Phone # () -

Responsible Party Name: _____ self spouse parent other

Have you contacted your Employer regarding this injury? YES NO

Work Comp Insurance Company _____

Claim Number Claim Adjuster: _____

Phone # () - Address _____

PRIVATE HEALTH INSURANCE:

Insured's Name Policy # _____

Insured's Date of Birth / / Insured's SS# - -

Insurance Provider Phone Number () -

Referring Physician Phone # () -

Date Last seen by physician / /

Emergency Contact Relationship spouse parent other

Address Phone # () -

How did you hear about Peak Physical Therapy? (Circle one)

Physician Family/Friend Previous Patient Advertisement Other _____

In order to submit claims on a timely basis, it is required that you provide complete information regarding the carrier, claim number, and date of injury. **If a workman's compensation claim is denied, the patient is responsible for payment.** Our office will file insurance claims for all reimbursable services to your worker's compensation carrier. You are responsible for all deductible, co-pay, and non-covered services amounts. If at any time your benefits are terminated/denied for any reason you consent to provide your private health insurance and allow Peak Physical Therapy to bill your private insurance for any unpaid balances. If unpaid balances are not paid or in the process of being paid off your account will be turned over to a collection agency within 180 days of your last date of service. I hereby consent to such physical therapy procedures as may be rendered by Peak Physical Therapy. There is also consent for authorization of all insurance benefits to be paid directly to Peak Physical Therapy, and assumption of all financial responsibility for the balance of charges not included in the insurance coverage. Peak Physical Therapy has the authority to release any information necessary to the insurance company for the processing of medical claims and to photograph for medical purposes only. Peak Physical Therapy is released from disclosure of the patient's records as provided by this paragrph.

Signature of Patient/Responsible Party

_____/_____/_____
Date



NO-SHOW, CANCELLATION POLICY

Our "No-Show, Cancellation Policy" is as follows: All patients who do not cancel their appointment within 24-hours or more of their scheduled appointment will be charged **\$20.00** at their next appointment. This fee can be waived for patients who re-schedule their appointment within that week.

Patients who do not show up to their appointment and do not call to cancel will receive a **\$25.00** "No-Show" fee.

I HAVE READ AND UNDERSTAND THE "No-Show, Cancellation Policy"

PATIENT/RESPONSIBLE PARTY SIGNATURE

____/____/____
DATE