MADDEN PHYSICAL THERAPY 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)

_____ **Date of Birth** _____/_____/_____

Name: Last First Initial

Emergency Contact Name_____ **Number** (_____) _____-_____

(2) Patient's Doctor: Please list the Doctor who referred you to therapy below.

_____ **Office Phone:** (___) _____-_____

Referring Dr's Name: Last First Initial MD, DO, DDS, Other

_____

Address: Street City,State Zip Code

(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: _____
PO BOX

Address: _____
City **State** **Zip Code**

Physical Address: _____
Street

Address: _____
City **State** **Zip Code**

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

All Patients or Patients' Legal Representative Please Sign Section 7 on Page 2

WORKERS' COMPENSATION
Patient & Payor Information Form

(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)

Ins. Co. Name:_____ **Ins. Co. Phone#:** _____

Insured's Name: _____ **Insured is** _____**Patient** _____**Spouse** _____**Parent**

Sex: M F **Birthdate:** _____/_____/_____

Patient ID#: _____ **Group#:** _____ **Policy/Plan #:** _____

Claims Mailing Address:_____

Street City State Zip Code
Employer Name: _____ **Employer Phone # (** **)** _____-_____

Address: _____ _____
Street City State Zip Code

(5) 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 Madden 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 Madden Physical Therapy to a Workers' Compensation payor 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 Madden Physical Therapy for treatment and payment under The Workers' Compensation Program is accurate and truthful. I will Advise Madden Physical Therapy Immediately if there is a change of my coverage/claim status**

(6) Attendance Policy:

ATTENTION!

In order to provide our patients with the best possible care, we maintain scheduled appointments. *If you cannot make a scheduled appointment, PLEASE contact us 24 hours before your scheduled time.* This will allow us to adjust our schedule appropriately.

_____ATTENDANCE POLICY
Initials

Individuals who attend 100% of their scheduled appointments will receive a free MADDEN PHYSICAL THERAPY gift. ***PATIENTS WHO CANCEL 3 TIMES OR NO-SHOW 2 TIMES WILL BE DISCHARGED.***

(7) Signature/ Date:

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

All Patients or Patients' Legal Representative Please Sign Section 7 on Page 2