BACK@WORK
PHYSICAL THERAPY

Last Name:_____ First:_____ M.I.____

Birth Date:_____ SSN:_____ Sex: M F

Street Address:_____

City:_____ Zip Code:_____Home Phone:_____ Cell Phone: _____

Who referred you of us?_____ Date of next doctor's visit:_____

Who is your primary care doctor?_____

Date of injury or onset:_____ Diagnosis/Problem_____

EmailAddress*:_____

** I wish to receive important, non-confidential information by email including appointment reminders, e-newsletters, and satisfaction surveys.*

Employer:_____ Employer Contact:_____

Employer Address: _____Work Phone:_____

Your Job Title:_____ How long at this position: _____

Is this injury work related? ☐ Yes ☐ No

Work Comp Insurance: _____ Claim number:_____

Contact person at work:_____ Phone: _____

Is this injury related to a car accident? ☐ Yes ☐ No (If yes please complete the following information)

Auto Insurance:_____ Auto Insurance Phone #:_____

Personal Insurance (Please present your card for copying)

Name of person insured: _____ Date of Birth of person insured:_____

CONSENT AND RESPONSIBILITY

Consent for services: Consent is hereby given to BACK@WORK PHYSICAL THERAPY, its contractors, medical staff, and employees to provide health care services to me and to administer physical therapy orders for my behalf. If I desire further information, I will make certain that the health care provider explain my condition and proposed treatment and answer my questions about the treatment and its risks in a satisfactory manner.

Release of Information: Permission is given for BACK@WORK PHYSICAL THERAPY, its contractors, medical staff and employees to release medical and other information about my case to insurance companies, to other third party payers who are or may be responsible to pay for all or any part of my health care services, and to the agents or representatives of such companies or payers. Such information may be released without further authorization for the purpose of making, completing and verifying claims and the receipt of services, in connection with prospective, concurrent, or retrospective review related to such health care services and the payment of such services. I also authorize the above named medical facility to release information to my employer or other medical specialist involved in the treatment of my case.

Responsibility: I understand that I am responsible for full payment of all charges incurred in connection with this visit, unless this is an industrial accident, in which case it will be covered by my employer's workers' compensation industrial carrier, or unless the service has been requested by my employer or prospective employer. I understand that if workers' compensation is denied for any reason, I am financially responsible

SIGNED:_____ DATE:_____