W. COMP PATIENT REGISTRATION

WORKERS COMPENSATION

Today's Date __________________

Date of Injury ______________Name ____
First MI Last

Address ____ ____
Street PO Box Apt #

Address ____
City State Zip

Home Phone _____-_____-_______ Work Phone______-______-________ Cell Phone______-______-_______

SS# ________-__________-______________ Male or Female Marital Status M S D

DATE OF BIRTH ___________________________ E-Mail : ____

Emergency Contact: ____ Phone: _______________________

Employer Information

Employer ____

Address ____ ____
Street PO Box Apt #

Address ____
City State Zip

Physician Information

Primary Care Physician Name ____

Address ____
Street City ST Zip

Phone _______-_________-______________ Fax _______-_________-_____________

Referring Physician Name ____

Address ____
Street City ST Zip

Phone _______-_________-______________ Fax _______-_________-_____________

Date of your return visit? __________________

Have you had physical therapy for this claim before? ___ No ___ Yes If yes, when?___________________

Worker Compensation Claim Information

Claim Number______________________________ Name of Employer at time of injury _____________________

Insurance Company Name ____

Address____
Street City State Zip

Phone ______-______-__________ Claims Adjuster _________________________________

ATTORNEY: Name ________________________________ Phone # ___________________________________

Attorney address: ____

Health Insurance Information

Primary Insured Name ________________________________ Insured Date of Birth _________________________

Relationship to insured ________________________________ Insured Phone # _____________________________

Insured Address if Different from Patient:

Address ____

Street City ST Zip

Health Insurance Co Name ____________________________________ Ins Phone #__________________________

Address____

Street City State Zip

Group Number__________________________________ ID Number__________________________

Contact Name ____

CONSENT TO TREATMENT

I hereby authorize the professional staff at **East Athens Physical Therapy** to examine and treat me with physical therapy for the injury I have been referred here for or referred myself to at _________________

Patient Signature	Date
Patient Printed Name	Staff Witness Signature
Parent or Guardian Signature	Date
Parent or Guardian Printed Name	Staff Witness Signature

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) ____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: East Athens Physical Therapy for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. I understand that **East Athens Physical Therapy**. complies with HIPPA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. The authorization is in effect until 90 days from the date the last bill is collected.

HIPPA REGULATIONS A photocopy of this Assignment shall be considered effective and valid as the original.
I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance under the HIPPA guidelines.

Patient Name (Printed)	Date	Patient Signature
Parent or Guardian (Printed)	Relationship	Parent or Guardian Signature

Witness ____________________________________ Date________________________________

East Athens Physical Therapy
Medical History

Patient Name____Age________

Type of Injury/Condition________________________________

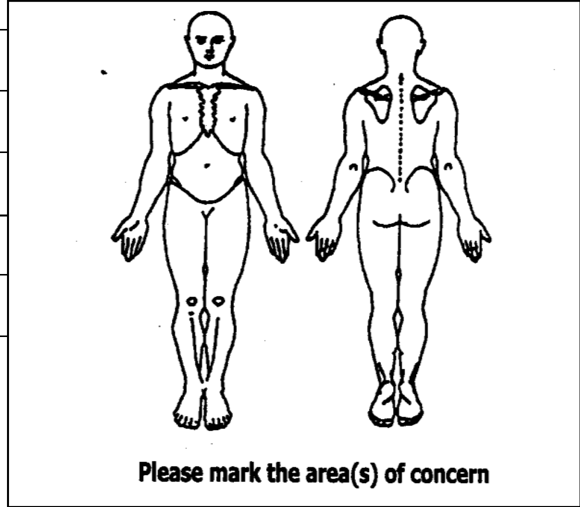
Onset/Injury Date_____________________________________

Type of Surgery & Date_________________________________

Next Doctor's Appointment_____________________________

Describe previous treatment for this condition_______________

____



Have you received chiropractic treatment this year? Yes / No

Have you had any imaging performed:

□ X-Ray □ CT Scan
□ MRI □ Doppler
□ Ultrasound

Have you recently noted:

□ Weight Loss / Gain □ Nausea / Vomiting □ Fatigue
□ Weakness □ Fever / Chills / Sweats □ Numbness / Tingling
□ Pregnant / IUD □ Headaches □ Change in Vision / Hearing
□ Pain at Night □ Cramps in Legs When Walking □ Insomnia

Do you have now or have you ever had any of the following:

□ Surgeries □ Loss of Consciousness □ Fractures
□ Sprains / Strains □ Diabetes □ Blood Pressure Problems
□ Heart Problems □ Cancer □ Motor Vehicle Accident
□ Circulation Problems / Clots □ Asthma / Breathing Problems □ Lung Disease
□ Easy Bruising / Bleeding □ Leg / Ankle Swelling □ Urinary Problems / Infections
□ Indigestions / Heartburn □ Fainting □ Allergies / Skin Sensitivity
□ Rheumatoid Arthritis
□ Any previous injury that may affect current care ____

Explain and give approximate dates for any items indicated above ____

____

Are you currently taking medications? Yes / No Name or Type of Medication _____________________________

____

Type of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other ___________________________

Rate your pain: At its <u>worst</u>: 1 2 3 4 5 6 7 8 9 10 At its <u>best</u>: 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment? ____

____

What are your physical or fitness goals? ____

____

____ _______________________

Patient or Personal Representative Signature **Date**

East Athens Physical Therapy

We at East Athens Physical Therapy strive to provide our patients with excellent service and quality care. Our commitment to your well-being and health care is something that we take very seriously.

Your commitment to your physical therapy program is critical to your success. We will recommend treatment and set goals for you. In order to reach those goals you must do your part and **your most important part is to make each and every appointment.**

We will give you an appointment card to keep track of your appointments. If you should misplace this, please give us a call to review your appointment dates. We expect you to keep all of your appointments; however, should you need to cancel, please note that we require a 24-hour notice.

If you need to cancel please call our office and reschedule as soon as possible so that we may open up your original time slot to other patients.

If you do not call or show up for your scheduled appointment, you will be charged a $25.00 “no show” fee.

If you miss 3 consecutive appointments, we will notify your physician and will require a new referral in order to continue your treatment.

Our staff will provide you with as much information regarding your insurance coverage. We will contact your insurance company and verify your physician therapy benefits. We will then let you know what your co-pay, co-insurance, deductible, etc. will be each time you come in for treatment. We encourage you to also call your insurance to find out your coverage and what your financial obligations may be.

Please speak with our Front Desk Specialist if you have any questions regarding your appointments, insurance, financial responsibilities, or any other issues.

Please speak with your therapist if you have any questions regarding your therapy treatment.

We thank you for choosing **East Athens Physical Therapy** and we look forward to working with you and helping you reach your goals.

The Staff at East Athens Physical Therapy

I have read and understand this policy:

____________________________________ ____________________________________

Patient/Guardian Date