Patient Information/Workers' Compensation

First Name | Initial | Last Name | Home Phone

Address | City | Zip | Cell Phone

Social Security Number | Birth Date | Marital Status S M D W | Sex M F

Employer Name | Address | City | Zip

Diagnosis | Referring Physician | Your E-mail Address

BILLING INFORMATION

Workers Compensation Insurance Carrier | Claim Number | Adjuster Name

Address | City/State | Zip | Phone

Date of Injury | Employer at time of Injury if Different than Above | Phone

Attorney | Phone

Authorization For Payment

I authorize payment of medical benefits to Evergreen Physical Therapy for services rendered to me. I understand that my workers' compensation insurance will not cover charges incurred by me for missed appointments and I will be responsible for payment of $50.00 for missed appointments unless I notify Evergreen Physical Therapy at least 24 hours in advance. In addition, I authorize the release of any medical information necessary to process my claims.

Recognition of Possible Symptom Irritability

I understand that physical therapy entails the movement of muscles and joints. For that reason, I understand that on occasion, I may experience increased symptom irritability subsequent to my treatment sessions.

SIGNATURE_____ DATE_____

**********For Office Use Only**********

DATE 1ST CALLED_____DATE FIRST APPT_____Patient Id#_____

Visits Authorized:_____By:_____Start Date_____End Date:_____