The Center for Balance
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)

Name: Last First Initial Sr. Jr.

Address: Street Apt# City State Zip Code

Phone: (_____) _____-_____ (_____) _____-_____ (_____) _____-_____ (_____) _____-_____
Home Mobile Work Emergency

(2) Patient

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

S.S # _____/_____/_____ **Legal Photo ID # _____**
(Driver's License, Passport, Other State/Federal Photo ID)

(3) Condition to be treated in Physical Therapy: _____

Is this Contition Due to a Work Injury? No Yes If Yes Date of Accident ____/____/____

Did this condition result in Surgery? No Yes If Yes Date of Surgery ____/____/____

Have you had PT anywhere this year for this condition? No Yes If Yes Where?_____ When?_____ How Long?_____

Have you had Chiropractic services for this condition? No Yes If Yes Where?_____ When?_____ How Long?_____

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

Referring Dr's Name: Last First Initial MD, DO, DDS, Other **Office Phone:** (____) _____-_____

Address: Street City,State Zip Code

All Patients or Patients' Legal Representative Please Sign Section 9 on Page 3

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(5) 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 #: (** **)** _____-_____

(6) Medical Insurance Information(please provide a copy of Insurance card and complete this section in the event that your Workers' Compensation claim is denied) Check A or B

A. ____ Patient is the insured

B. ____ Insured is ___Spouse ____Parent

_____
Name: Last First Initial Sr./Jr.

_____
Address: Street Apt.# City State Zip Code

Phone: (___) ____-_____ (___) ____-_____ (___) ____-_____ (___) ____-____
Home Mobile Work Emergency

Date of Birth: ____/____/____ **S.S. #** _____/_____/_____ **Legal ID #** _____

Insured's Sex: M F **___ Employed ___ Unemployed ___ Retired**

Ins. Co. Name: _____ **Patient ID #:** _____**Group. #** _____

Policy/Plan #: _____ **Ins. Ph #**_____

Claims Mailing Address:_____
Street City State Zip Code

Employer Name: _____ **Employer Phone # (** **)** _____- _____

Address: _____ _____
Street City State Zip Code

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(7) Medications : (This includes prescriptions (from your doctor), over the counter drugs, herbal and nutritional supplements)

Separate List Provided Yes No If, No please complete this section

Medication/Drug Name	Dosage	Number of Times Per Day

(8) 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 *FACILITYNAME 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 *FACILITYNAME 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 *FACILITYNAME for treatment and payment under the Workers' Compensation Program is accurate and truthful. I will advise *FACILITYNAME immediately if there is a change of my coverage/claim status**

(9) Signature/ Date:

_____ _____

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

All Patients or Patients' Legal Representative Please Sign Section 9 on Page 3