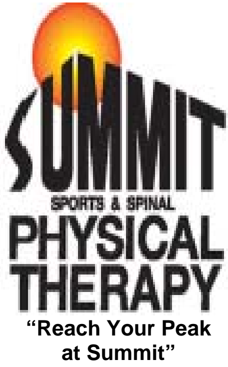

WORKER'S COMPENSATION INSURANCE FORM

Today's Date: ______________

Name: ______________________________ Date of Birth: _______________ Age: ______

Address: Street ______________________________ APT# ______ *Phone #: ____________________

CITY ______________________________ ZIP ______ *Other #: ____________________

*Sex: M / F *Social Security #: ___________________ *Marital Status: _______________

WORK STATUS & INFO: ☐ Part Time ☐ Full Time ☐ Not Employed ☐ Retired

Patient Occupation: ___________________________________ Employer: ______________________________

Contact Person: _______________________________________ Work Phone #: ___________________________

1. Have you notified your employer of this injury? YES / NO **2.** Has your employer authorized treatment? YES / NO

In case of an Emergency, whom do we contact?

Name: ____ Relationship: _________________________

Address: ____ Phone #: ____________________________

INSURANCE INFO

Insurance Company: _________________________________ Claim / Case #: ___________________________________

Adjuster's Name: _____________________________________ Phone & Fax #: ___________________________________

Attorney's Name (if any): _______________________________ Address / Phone #: _________________________________

INJURY INFORMATION

Where's the injury located? _______________ Date of Injury: _______________ Surgery Date (if any): _______________

Have you had previous treatment for this injury? NO / YES : If yes, when & where? _______________________________

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company Name: _____________________________________

I hereby instruct the above named Insurance company/companies to pay by check made out to and mailed directly to:

Kieran J. Tryanor, P.T., P.C – dba Summit Sports & Spinal Physical Therapy
1420 Boston Post Road
Larchmont, NY 10538

For professional or medical expense 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 also agree to pay interest on any balance past 90 days. I understand that Summit Sports & Spinal Physical Therapy complies with HIPAA and protect my PHI and will use it as allowable by law in the Treatment, Billing & Collections pertaining to my care until my case is closed and full payment received. **Complete HIPPA policy available upon request.** 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. This authorization is in effect until 90 days from the date the last bill is collected. **A photo copy of this Assignment shall be considered effective and valid as the original.**

Patient Signature: ____________________________ *Patient Name Printed:* __________________________ *Date:* _______________

Parent/Guardian Signature: ______________________________ *Parent/Guardian Name Printed:* ______________________________

PLEASE COMPLETE THE BACK OF THIS FORM AS WELL

***HEALTH HISTORY** **(please circle any that apply) :**

Irregular Heart Beat   Chronic Bronchitis   Pacemaker   Heart Surgery   Heart Attack   Asthma   Cancer   Arthritis

Bleeding Disorders   Kidney Disorders   Osteoporosis   Emphysema   Hay Fever   Angina   Seizures   Smoker

Heart Valve Problem   High Blood Pressure   Emphysema   Other Problems/ Surgeries/ Broken Bones - ____________________

Diabetes - *Do you take insulin? _________ * How often do you take glucose? _________   Gastrointestinal Disorder - Type: _______________

How did you hear about us? ☐ Doctor: _______________ ☐ Phone Book ☐ Friend / Relative ☐ Other: _______________

Cancellation / No Show Policy:

Please call our facility with **24 hour** notice if you need to change or cancel your appointment. After the **THIRD CANCELLATION** or **NO SHOW** without 24-hour notice, will result in a **$25 cancellation fee.** If appointment is rescheduled for same or next day, it will not be counted as a cancellation. **I am aware of Summit's cancellation policy:**

Signature: ____   Date: __________________

Financial Responsibility:

I assign all medical benefits and authorize my insurance carrier(s) to issue payment directly to Summit Sports & Spinal Physical Therapy and/or my therapist. I understand that Summit will bill my insurance carrier(s) directly for services rendered, however, if the insurance carrier(s) should deny responsibility for these claims, I understand I will be held responsible. Failure to pay bills in a timely manner will result in a 40% account increase to compensate Summit for collection agency fees. I further authorize the release of my physical therapy records to insurance companies in order to process claims.

Signature: ____   Date: __________________

Privacy Practices:

This acknowledgement reflects the privacy standards set forth by the Department of Health and Human Services. A copy of Summit Sports & Spinal Physical Therapy's privacy practices is located at the front desk. You may also request a copy for yourself.

Signature: ____   Date: __________________