Therapy One - WORKERS COMP REGISTRATION FORM

Please Print

Date:	PCP:

1. PATIENT INFORMATION

SS#	Last Name	First	Middle	Age

Street Address:	City:	State:	Zip:
Mailing Address (If different):	City:	State:	Zip:

Home Phone	Cell Phone	Birth Date:	Sex:		Single
( )	( )		M	F	Married

Employer:	Employer Address:	Employer Phone:

2. PATIENT CALL BACK INFORMATION

Therapy One uses an automated call back system to remind our patients of their next appointment. Please indicate if your prefer to have a voice or text message reminder and please proivde the appropriate cell phone number that will receive the text message, or home number if you prefer a voice call back.

I prefer a: ☐ Voice Messsage ☐ Text Message

Please call or text my: ☐ Home Phone ☐ Cell Phone (provide the appropriate number above)

3. INJURY INFORMATION

Date of Injury: _____

Describe in detail how the injury occurred: _____

_____.

Describe the pain and it's location: _____

Have you ever had this or a similar condition in the past?	No	Yes	When?
Have you been treated by a physician for this condition?	No	Yes	Where?

4. EMERGENCY CONTACT

Name: _____. Phone (home/work/cell): _____.

5. CANCELLATION & "NO SHOW" POLICY

☐ YES - I understand that all appointments cancelled <24 hours (without rescheduling) and “no shows” will be reported to my physician and the workers compensation insurance company

Initials: Date:

6. AUTHORIZATION TO RELEASE INFORMATION

I acknowledge that the above information is true to the best of my knowledge. I authorize Therapy One to treat as necessary. I authorize payments of medical benefits directly to Therapy One for treatment of any and all illnesses and/or injuries for which treatment or screening is sought. I understand that I will be financially responsible for all charges deemed non-compensable, for any reason, by my employer's Workers Comp carrier.

I authorize the release of results of any medical examination and/or testing performed to the employer requesting the examinationand/or testing. I also authorize release of results to my Workers Comp carrier as needed to facilitate payment to Therapy One.

X _____. _____

Signature Date

7. NOTICE OF PRIVACY PRACTICES

I, the undersigned, acknowledge that I have received/been offered a copy of Therapy One's Privacy Practices.

X _____. _____

Signature Date