Frankfort Physical Therapy, LLC.

7777 W. Lincoln Hwy * Frankfort, Illinois 60423 * (815) 806-8777

Work Comp Patient Information

Patient Name:_____
Patient Address:_____
City,State,Zip:_____
Phone:_____
Patient SS#:_____
Date of Birth:_____ **Age:**_____
Patient Status: Single____ Married____
Divorced____ Other____

Employer:_____
EMPL Address:_____
City,State,Zip:_____
Phone:_____
Date of Injury:_____
Name of Relative to contact in case of emergency:
Name:_____ **Relationship:**_____
Phone:_____

Insurance Information

W/C Insurance Company:_____
Claims Adjustor:_____
Phone:_____

Rehab Nurse:_____
Phone:_____
Claim#:_____

Release of Information

I GIVE PERMISSION TO FRANKFORT PHYSICAL THERAPY, LLC. TO RELEASE INFORMATION TO MY INSURANCE COMPANY, ATTORNEY, ASSIGNES AND/OR BENEFICIARES.

SIGNATURE:_____ **DATE:**_____

Assignment of Benefits

I AUTHORIZE PAYMENT DIRECTLY TO FRANKFORT PHYSICAL THERAPY, LLC. FOR SERVICES RENDERED TO THE PATIENT NAMED ABOVE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY MY GROUP INSURANCE PLAN.

SIGNATURE:_____**DATE**:_____

OUR FINANCIAL POLICY

We have found that communication with our patients regarding our financial policy assists us in providing the best services to you. Please take time to read the following. Your signature is required below. Thank You.

WORKER'S COMPENSATION – All preauthorized bills will be directly billed to the Worker's Compensation carrier. In the event that your claim becomes denied or disputed, you will be responsible for payment and a payment plan will be arranged with the billing manager or we will be happy to file any other insurance claims for you.

AGREEMENT TO PAY

I understand that I am responsible and liable for payment of all charges assessed for professional services rendered. I understand the financial policy detailed above. I understand that I am primarily responsible for all charges (including late charges) regardless of my existing medical coverage of payment plan. In the event my insurance company forwards payment directly to me, I will deliver such payment to Manteno Physical Therapy, LLC. I understand that I am responsible for meeting my insurance deductible and co-insurance and any non-covered services. Should my account become past due, the balance my responsibility and is immediately due and payable and I will be responsible for all collection and legal costs including reasonable attorney's fees.

ON ATTEMPTING TO VERIFY YOUR INSURANCE BENEFITS, THE FOLLOWING INFORMATION WAS OBTAINED:

Patient:_____
Your Worker's Compensation claim has been approved by:_____
Verified by:_____

Patient's Signature:_____ **Date:**_____
Witness:_____

CANCELLATION POLICY

In order to best serve all of our patients, the following policies have been established.

1. A 24 hour notice of cancellation will be requested should you be unable to keep a scheduled appointment. If scheduled appointments are repeatedly canceled, a cancellation fee will be charged, This will have to be paid prior to the next treatment session.
2. Failure to appear for 3 or more appointments may result in therapy being discontinued, and your doctor will be notified.
3. In order to resume treatment, new referral or prescription will be required.

Respectfully,
Frankfort Physical Therapy, LLC.

I have read and understand the above policies: _____
Signature Date