

Manteno Physical Therapy, LLC.

19 West Division Street * Manteno, Illinois 60950 * (815) 468-7300

Work Comp Patient Information

Patient Name: _____ Employer: _____
Patient Address: _____ EMPL Address: _____
City, State, Zip: _____ City, State, Zip: _____
Phone: _____ Phone: _____
Patient SS#: _____ Date of Injury: _____
Date of Birth: _____ Age: _____ Name of Relative to contact in case of emergency:
Patient Status: Single _____ Married _____ Name: _____ Relationship: _____
Divorced _____ Other _____ Phone: _____

Insurance Information

W/C Insurance Company: _____ Rehab Nurse: _____
Claims Adjustor: _____ Phone: _____
Phone: _____ Claim#: _____

Release of Information

I GIVE PERMISSION TO MANTENO PHYSICAL THERAPY, LLC. TO RELEASE INFORMATION TO MY INSURANCE COMPANY, ATTORNEY, ASSIGNEES AND/OR BENEFICIARIES.

SIGNATURE: _____ DATE: _____

Assignment of Benefits

I AUTHORIZE PAYMENT DIRECTLY TO MANTENO 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,
MANTENO PHYSICAL THERAPY, LLC.

I have read and understand the above policies: _____

SIGNATURE

DATE
