FOCUS PHYSICAL THERAPY

Patient Name:_____ Date:_____

WORKERS' COMPENSATION
ACCIDENT and CLAIM INFORMATION*

Admin: ☐ Check Complete

Injury Date _____
Social Security Number _____
Employer Policy Name _____ Claim Number _____
Mailing Address _____
City _____ State _____ Zip _____

Adjuster Name _____
Adjuster Phone _____
Adjuster Email _____
Unable to work from (dates): _____ to: _____

*Please give claim acceptance letter and private insurance card to staff for scanning.

WORKERS' COMPENSATION POLICY

In most cases, Focus Physical Therapy, Inc. will bill your workers' compensation and your private health insurance when necessary however, any account balance incurred with Focus and not paid by the workers' compensation carrier or your private health insurance is legally your responsibility.

As an injured worker, please note that Focus does verify the validity of all workers' compensation claims and their status. We require, prior to treatment, that claims noted as deferred must be supplemented with private health insurance if available. A copy of your identification card will be required at your first visit.

I, the undersigned, agree and understand that as an injured worker and patient with Focus that I am ultimately responsible for the balance of my account for any professional services provided should my workers' compensation claim be denied.

_____ _____
Signature of Patient or Responsible Party Date