# PHYSICAL THERAPY SERVICES

## CONDITIONS OF ADMISSION FOR WORKER'S COMPENSATION PATIENTS

**TREATMENT CONSENT:**
I request and authorize the staff of Physical Therapy Services, (PTS), to provide me with treatment and to perform any procedures now contemplated or such additional procedures as my doctor or therapist may deem reasonable and necessary for my condition. I understand this (these) treatment(s) will be performed by an appropriately credentialed staff member employed by or acting as an agent of PTS. I further understand that I may ask and have any questions answered by my therapist pertaining to the treatments being utilized, including information about significant risks, benefits of and alternatives to the procedures. I further acknowledge my right to rescind this consent at any time.

**RELEASE OF INFORMATION:**
PTS may disclose all or any part of my record to any person, group or corporation which is involved in the plan of care or may be liable under a contract with PTS or with my employer for all or part of PTS's charge, including but not limited to, insurers, medical service companies, workers compensation carriers, or my employer. This disclosure of my record may be either in writing or by oral communication.

The undersigned certifies that he/she has read the foregoing and is the patient, or is duly authorized by the patient as patient's general agent to execute the above and accept its terms. It is further understood that this release remains in effect for one (1) year unless otherwise revoked.

Signature:_____ Date:_____
(Patient or legal guardian)

**MISSED APPOINTMENTS:**
PTS requests a 4-hour prior notification for appointment cancellation. Missed appointments are recorded in the medical record. Several missed appointments may indicate to your work comp carrier/adjustor/case manager/ and/or employer lack of patient compliance with the plan of care.

**ASSIGNMENT OF BENEFITS:**
I hereby authorize _____(Insurance Company) to pay directly to Physical Therapy Services all benefits due me, if any, by reason of services described in the statements rendered. I understand that PTS has the same right as I do to appeal the carrier's determination.

Patient or Patient's Agent:_____ Date:_____

**FINANCIAL RESPONSIBILITY:**
Although we verify the existence of an active work comp claim on your behalf, this is not a guarantee of payment. Occasionally, the condition for which you receive physical therapy treatment is determined to not be related to your work injury. If this situation should occur, you will then be financially responsible for the charges. We will be glad to file your health insurance for coverage consideration. You will be responsible for any portion of the bill not covered by health insurance. All patients with a date of work injury greater than one year old are required to provide health insurance information upon registration at PTS. The undersigned certifies that he/she has received an explanation of the treatment costs and is the responsible party and accepts these terms.

Responsible Party and/or Trustee of Patient's Funds:_____ Date:_____

Witness:_____ Date:_____