WORKMAN'S COMPENSATION
Employer _____ Contact Person/Phone _____
Address _____ City/State/Zip _____
Job Title: _____ Date of Injury _____

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AUTO INSURANCE COMPANY _____
Address _____ City/State/Zip _____
Contact Person/Phone _____

****

If ATTORNEY has been retained:
Attorney's Name _____ Phone _____
Address _____ City/State/Zip _____

****

Special Instructions: _____

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OUR POLICIES

1. You will be billed monthly for your copayment (10%, 20%, etc.). We reserve the right to require payment in full at the time of service for any account, but particularly from those that do not make their monthly payments.
There is a $20.00 fee on all returned checks.

2. A minimum payment per visit is required prior to treatment from patients who are:

A) Cash pay (non-insured, high un-met deductible) = $10.00 p/visit
B) in dispute as to whether or not a claim is Worker's Comp = $10.00 p/visit
C) Litigation (car accident, liability etc.) = $15.00 p/visit

3. Responsibility for the full charges of your physical therapy services are yours. It will be necessary for you to make the proper arrangements to handle the uninsured portions of our charges. As a courtesy to you, we will file your primary insurance free of charge on our standard form, provided all necessary information is given. If your company requires special, additional forms to be filed, you will be charged a filing fee of $20.00. If you are unable to abide by the above policy, please make arrangements with our office staff.

4. Consistent attendance is essential to successful rehabilitation. Three (3) absences and/or repeated tardiness for scheduled appointments may be deemed excessive and may result in your being discharged from our facility.

5. We reserve the right to withhold the release of your medical records if your account is delinquent.

The statements contained herein are true and complete to the best of my knowledge. I understand fully the payment policy and billing procedures of HealthWorks. I hereby authorize HealthWorks to furnish my insurance company, attorney or legal representative all information which said parties may request concerning my present illness, injury or condition.

I hereby assign to HealthWorks, all money to which I am entitled for medical expenses relative to the service reported herein, but not to exceed my indebtedness to HealthWorks. It is understood that any money received from the above-named parties over and above my indebtedness, will be refunded (either to me or my insuror, whichever is the source of the over-payment) when my bill is paid in full. I understand I am financially responsible to HealthWorks for charges not covered by my insurance company. I certify by my signature that I have read and agree with this information. I also certify that I consent to evaluation and treatment by the staff of HealthWorks.
A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

<u>Important Notice</u>: Cell Phones are <u>not</u> allowed in HealthWorks Treatment Areas. Please turn off your cell phone or leave it in your car. Thank you for your cooperation.

_____ _____ Date _____
Patient's Name (please print) Patient's Signature

_____ _____ Date _____
Parent's/Responsible Party's Name (please print) Parent's/Responsible Party's Signature (if applicable)

12/07