Alves & Martinez
Physical Therapy & Athletic Performance

WORKERS COMPENSATION
PATIENT INFORMATION

Name: ____________________ Birth date: ______________ Sex: ☐ Male ☐ Female

SSN: __________ - ________ -__________ Driver's License #: __________________ State: __________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other What's your Primary Language? ____________

Are you student? ☐ Not a Student ☐ Full-Time Student ☐ Part-Time Student

Home Address: ______________________ City ________________ State ______ Zip __________

Mailing Address (if different from home address):
______________________ City________________ State_____ Zip________

**** Please provide your contact phone numbers and check your preference (primary):**

☐ Home Phone: ________________ ☐ Cell Phone: ________________ ☐ Other #: ________________

Email Address: ______________________________________

How would you like to receive appointment reminders? ☐ Voice Call ☐ Text ☐ Email

How did you hear about our clinic? ______________________________________

Referring Doctor: ____________________ Referral Date: ______________

Insurance Name: ______________________________

Address: ______________________ City ________________ State _____ Zip __________

Adjuster: ______________________ Phone: ________________ Fax: ________________

Nurse Case Manager: ______________________ Phone: ________________ Fax: ________________

Claim# ______________________ Date of Injury ______________ Surgery: ______________

Job Title (Occupation): ____________________ Employment Status before injury: ☐ Full-Time ☐ Part-Time ☐ Other ___

Employer Name: ______________________ Employer phone: ______________________

Address: ______________________ City ________________ State ______ Zip __________

Attorney Information (If have one under your WC claim):

Attorney Name: ______________________ Phone: ________________ Fax: ________________

Address: ______________________ City ________________ State ________ Zip __________

TURN OVER

CONSENT FOR TREATMENT/ASSIGNMENT OF BENEFITS
I, the undersigned, do hereby agree and give my consent to and authorize my physical therapist and other healthcare professionals and/or assistants at Alves & Martinez Physical Therapy and Athletic Performance who may be involved in my care, to provide medical care and treatment prescribed and considered necessary by my physician(s). I acknowledge that no guarantees have been made to me about the results of treatment.

APPOINTMENT ATTENDANCE AGREEMENT
I understand the importance of attending therapy consistently and arriving promptly for my appointment(s). In case of running or arriving late, I acknowledge that I may be rescheduled if its more that 15 minutes late of the appointment time. This is for the benefit of me and other patients being treated. I also understand the importance of scheduling appointments in advance and acknowledge that appointment(s) times given one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours notice when cancelling or rescheduling an appointment.

ACCESS TO AND RELEASE OF HEALTH INFORMATION
I understand that Alves & Martinez Physical Therapy and Athletic Performance may document medical and other information related to my treatment electronically and other forms, and that such information will be used in the course of my treatment. This will be for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I authorize my physical therapist and/or administrative staff at Alves & Martinez Physical Therapy and Athletic Performance to contact other healthcare professionals that may have information related to my prior and current health condition(s). I acknowledge that I have received *Alves & Martinez Physical Therapy's Notice of Information Practices* and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

HIPAA AUTHORIZATION
In compliance with the HIPAA regulations, I authorize the following individuals to receive verbal information regarding my care at Alves & Martinez Physical Therapy and Athletic Performance and/or the billing of my account.

1.________________________________ 2.________________________________ 3.________________________________
Name/Relationship Name/Relationship Name/Relationship

CONSENT FOR EMERGENCY CONTACT INFORMATION
Person to contact in case of an emergency:

____________________________________ _________________________ _____________________
Name Phone Number Relationship

By given my signature below, I freely and voluntarily certify that I have read, understand and fully agree to each of the statements in this document and that all of the information provided herein is true and correct.

Patient or Guardian Signature: ______________________________________ **Date:** _____________________