PATIENT INFORMATON Car Accident or Workers Compensation

Last Name_____ **First Name**_____**Middle**_____

Date of Birth _____ **Social Security #** _____**Email**_____

Address_____ **City** _____ **State**____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **Appt Reminder** __ **Call** __ **Text** __ E-Mail

Employment Status;____ **Employed**_____ **Unemployed** _____**Self-Employed** ____**Student** ____ **Retired**

Employer_____ **Occupation** _____

Emergency Contact Name _____ **Phone Number**_____

Relationship to Patient ____**Spouse** ____**Mother**____ **Father**____ **Other**_____

Primary Care Physician_____ **Referring Physician**_____

How did you hear about our office_____

Workers Compensation / Car Insurance (Patients own Car Insurance ONLY)

Insurance Company _____**Phone #** _____ **Date of Injury/Accident** _____

Adjustor _____**Claim #**_____

Claim address_____

Personal Health Insurance _____ **SEE COPY OF INSURANCE CARD**___
Name of Subscriber _____**Date of Birth**_____
ID # _____ **Group #** _____

POLICIES

If the following therapies are applicable to my treatments (to be discussed individually with therapist)

I give permission to Bodywise Physical Therapy, LLC to perform dry needling therapy.
I give permission to Bodywise Physical Therapy ,LLC to perform manipulation therapy
I give permission to Bodywise Physical Therapy, LLC to perform laser therapy.

Patient Name _____ **Date** _____

Patient/Guardian/Responsible Party Signature_____

I give permission to Bodywise Physical Therapy ,LLC to render treatment as needed

I give permission to Bodywise Physical Therapy, LLC to release my records to my physician, insurance or W/C.

I give permission to Bodywise Physical Therapy, LLC to obtain my records from my Physician for this case.

Patient Name _____ Date _____

Patient/Guardian/Responsible Party Signature_____

WORKERS COMPENSATION - CAR ACCIDENT

I understand I am responsible for the balance on this account if my workers compensation claim is denied.

I understand I am responsible for the balance on this account if my car Insurance Benefits are exhausted / denied.

I understand Bodywise Physical Therapy LLC will bill my personal health insurance if workers compensation or my car insurance denies payment.

I am responsible for any cost associated with my personal Health Insurance.

In the state of NH car insurance will send payment for therapy render directly to the patient. I **AGREE** to pay Bodywise within two business day of receiving payment. Bodywise Physical Therapy accepts insurance checks written over to Bodywise Physical Therapy

Patient Name _____Date _____

Patient/Guardian / Responsible Party Signature _____