MOVE BETTER
PHYSICAL THERAPY

WORKMAN'S COMPENSATION CONSENT FORM

We are dedicated to your treatment and take pride in the quality care that we deliver. In order to avoid misunderstandings we provide the following information:

If you state that your injury occurred while you were working at your job and you wish to file a claim with your employer's workman's compensation carrier, you must provide the **claim number** and address to which claims are to be sent. As a courtesy to you, we will file insurance claims to the workman's compensation carrier that you requested. However, should your claim be denied by workman's compensation, you will be responsible for the entire claim. If your secondary insurance does not require pre-authorization or referral from your primary care physician, we will attempt to bill your secondary insurance. However, your secondary insurance company can also deny your claim and then you will be responsible for the entire claim. If your secondary insurance does require pre-authorization and/or a referral from your primary care physician and you did not get pre-authorization and/or referral from your primary care physician, your secondary insurance will not pay your claim and you are responsible for the entire claim. We can provide you with a billing statement that you can file with your company in case your company has a flexible medical spending plan.

I, _____ understand the above information and agree to the terms as specified above by MOVE BETTER by the presence of my signature below.

Patient signature: _____ Date: _____

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