

**WORKER COMPENSATION
INFORMATION**
(PLEASE PRINT)

PROFESSIONAL REHABILITATION SPECIALISTS, P.A.

380 Limit Street
Leavenworth, KS 66048

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____ Home Phone # _____

City _____ State _____ Zip _____ Date _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Do You Have Or Have You Ever Had Cancer? Yes No

EMPLOYER

Employer Name _____ Occupation _____

Employer Address _____ Employer Phone # _____

Injury Verified By (For Office Use) _____ Contact Person _____

WORKER COMPENSATION CARRIER (FOR OFFICE USE)

Worker Compensation Carrier _____

Carrier Address _____

Carrier Phone # _____ Carrier Fax # _____

Adjuster's Name _____ Adjuster's Phone # _____

Claim # _____ Coverage Verified By _____

INJURY INFORMATION

Date Of Injury _____ Name Of Person You Reported Accident To _____

FINANCIAL POLICY

Your co-pay will be due at each visit to our office. **AS A SERVICE TO YOU**, we will file a maximum of (2) insurances. Any additional filing is the responsibility of the patient. The portion not paid by your insurance is the responsibility of the patient. If payment has not been received from your insurance within 90 days after we file, the entire balance will then be due and payable by you. We accept cash or check as payment for services. If you need to establish a payment plan do this with the insurance coordinator during the first visit to our office, not after your bill is overdue. A statement, showing the amount you owe, will be sent to you after your insurance has assigned contractual discount and paid its portion. Accounts showing no payment (30) days after a statement is sent will accrue a finance charge of 1.5% per month. Accounts showing no payment or approved payment plan after (90) days will immediately be turned over to our collection agency. At this point and time the patient will become responsible for any and all collection/attorney fees. If there are potential financial situations, which causes your medical expenses to be currently difficult to handle, please let our billing staff help you work out a plan prior to the beginning of the legally required collections process.

ASSIGNMENT AND RELEASE (HIPPA)

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Professional Rehabilitation Specialists, PA. (PRS) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges or portion of charges whether or not paid by insurance. I give consent to PRS for use and disclosure of all protected health information to carry out treatment, insurance filing, payment, collections and healthcare operations.

Responsible Party Signature

Relationship

Date