ALHAMBRA VALLEY
PHYSICAL THERAPY

WORKERS COMPENSATION FINANCIAL AGREEMENT

I understand that I will not be billed for any services if my injury is work related; however if my case is denied by the insurance carrier as not work related, or if this office's services are denied as not related to my work injury, then I will be responsible for all outstanding charges.

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Initial

I understand that if I do not cancel a scheduled appointment within 24 hours, no show to a scheduled appointment, or am more than 15 minutes late and my scheduled appointment needs to be cancelled, that my worker's compensation adjustor will be notified after the second occurrence, and I will be referred back to the referring doctor after the third occurrence.

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Initial

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to be paid directly to:

Alhambra Valley Physical Therapy; Joan Arieta, RPT, DPT.

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Initial

PLEASE CHOOSE ONE. Reminder calls are automated, by either text or voicemail. Please check which option you would like, or you may opt out of receiving reminders by checking none:

o Home:_____ o Cell: _____ o Text: _____ o None

I have read, understood and agree to the policies listed above. I have been given the opportunity to ask questions, and can be provided copies if requested.

Signed:_____Print Name:_____Date:_____

Address:_____Occupation:_____