



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 Albemarle Physical Therapy, PLLC by the presence of my signature below.

Patient signature: _____ Date: _____

