HUDSON VALLEY ORTHOPAEDIC & SPORTS PHYSICAL THERAPY PAYMENT AGREEMENT FOR PATIENTS WITH WORKER'S COMPENSATION CLAIMS

Hudson Valley Orthopaedic & Sports Physical therapy is committed to provide you with the best possible care. Please read the highlighted sections below that pertain to your treatment and insurance coverage. If you have any questions, please do not hesitate to ask our staff. The charges for your visits are mandated by the New York State (NYS) Compensation Board and may vary depending upon the treatment you receive during any given visit.

REFERRALS: New York State law requires all patients treated by a physical therapist must be referred by a medical doctor, dentist, podiatrist, physician assistant or nurse practitioner. The referral and /or prescription must be currently dated and in writing. A return visit or call to your referring physician may be required if your therapy is to continue beyond your written prescription. Please discuss your condition with your physical therapist and inform the therapist and/or the desk staff of any scheduled appointment with your referring physician.

WORKER'S COMPENSATION (WC) PATIENTS: By law, all employers in New York State must provide medical compensation for their employees who are injured while on the job. The **NYS Compensation Board mandates the rules and regulations governing the treatment of those injuries. (Excluded** from the domain of the NYS Compensation Board are employees of out-of-state employers, Metro-North Railroad and the Federal Government.**) Injured parties must file a valid claim with their employer.**

AUTHORIZATION REQUIREMENTS: Effective December 10, 2010, NYS Worker's Compensation Board has made changes to their Guidelines for physical therapy treatment of the following injured body areas:

- **Knee, back or neck injuries may be treated up to a maximum of 8 weeks with a medical doctor's prescription.**
- **Shoulder injuries may be treated up to 12 weeks.**
- **Carpal Tunnel injuries may be treated up to a maximum of 6-12 weeks per NYS Worker's effective March 2013.**

It is the responsibility of your referring physician to apply for authorization from your employer's compensation carrier for your initial physical therapy treatment. It is important for you to know: the insurance carrier will only reimburse for the physical therapy treatment they have authorized.

All charges will be billed to your employer's compensation carrier. You are not financially responsible for the charges incurred in the treatment of your work related injuries; however, you will be responsible for any items purchased during your visits that your carrier will not reimburse.

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Please print the information requested on both sides of this form and return it to the front desk. Thank you.

Date _____

Worker's Compensation Information:

Injured Person Name: _____
First Middle Last

Employer at the time of injury: _____

Address: _____
Street/PO Box City State Zip Code

Employer's Compensation Insurance Carrier: _____

Contact /Case Manager: _____ Phone: _____Fax #:_____

Mailing Address for claim submission: _____
Street/PO Box City State Zip Code

WCB CASE NUMBER _____ CARRIER CASE NUMBER _____

DATE OF INJURY_____TIME OF INJURY (AM or PM) _____

CITY, TOWN OR VILLAGE where injury occurred_____
(If out-of state, list city & state)

(Continued on reverse side)

□ Are you working now? (Yes or no) _____

□ Have you ever been treated by another Physical Therapist for this injury? (Yes or no)_____
□ If yes, please list the name of the therapist_____
□ Address of therapy office_____
□Approximate dates of treatment_____

□ PLEASE GIVE A BRIEF DESCRIPTION OF THE NATURE OF YOUR INJURY AND HOW AND WHERE IT OCCURRED:

□ I understand the compensation regulations as outlined above and have or will provide, in a timely manner, all the necessary information to fulfill these requirements.

□ In the event it is determined that your injury is not work related and your named compensation carrier is not responsible for your charges from this office, you will be responsible for the total balance of your account. It is important for you to provide this office with all current information regarding your injury and work status, so we may comply with the written requirements of the NYS Compensation Board.

□ SIGNATURE OF INJURED PERSON: _____

Worker's Compensation Patients: Please list below your private insurance information.

□ Insurance Company Name: _____

□ Insurance Company Billing Address: _____
Street/PO Box City State Zip Code

□ Insurance Company Phone #: _____

□ Name of policyholder if other than the patient: _____
First Middle Last

□ Insurance ID# _____ Group # _____

□ If an employer provides the above named insurance, please name employer: _____

□ If my worker's compensation are denied for any of the reasons as stated above, I authorize Hudson Valley Orthopaedic & Sports Physical Therapy to bill my above named private insurance company for my physical therapy treatment.

□ Signature of patient and/or legal guardian: _____

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