Clawson Physical Therapy
Workers Compensation

Only fill this form out if your injury occurred at work

☐ **1075 Fulton Avenue Suite A**
Sacramento, CA 95825
916-488-4000 phone
916-488-4005 fax

☐ **6915 Elk Grove Blvd Suite A**
Elk Grove, CA 95758
916-684-3000 phone
916-684-3003 fax

First Name: **Init:** **Last Name:**
Home Phone: **Cell Phone:** **Email:**
Employer Name:
Employer Phone:
Employer Address:

Please describe how you were injured at work:

Surgery: Yes No **Date:**
Primary Complaint:
Location of pain:
Rate your pain on a Pain Scale of 0-10: (10 being the worst) Worst pain: Best: Current:
Aggravating Factors: (Circle all that apply) Sitting Standing Walking Stairs
Pain Description: (Circle all that apply) Dull Achy Shooting Throbbing Numb Tingly Constant Intermittent
Medical History: (Circle all that apply) Diabetes T1 Diabetes T2 High Blood Pressure Fracture Heart Condition Lung Condition Other:_____
Please list any other conditions/surgeries that may affect your therapy:

Medication List:

Clawson Physical Therapy

INSURANCE RELEASE

Name _____ Birth date _____

Social Security # _____-_____-_____Driver's License # _____

Insurance Company _____Member ID# _____

Secondary Insurance _____Member ID# _____

Doctor's Name and Phone # _____

With regards to medical care and services provided, it is agreed that David T. Clawson, MPT and Clawson Physical Therapy, it's Physical Therapists and Physical Therapy Assistants provide medical care and services to the patient such as: physical therapy and any other services deemed necessary and rendered to the patient by David T. Clawson, MPT, Clawson Physical Therapy, staff, physical therapists, physical therapy assistants, according to the best of their skill and knowledge.

David T. Clawson, MPT and Clawson Physical Therapy will obtain the patient's consent and his/her written authorization to release information, other than basic information, concerning the patient, except in those circumstances when David T. Clawson, MPT and Clawson Physical Therapy is permitted or required by law to release information.

The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, David T. Clawson, MPT and Clawson Physical Therapy may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of David T. Clawson, MPT and Clawson Physical Therapy's charges, including but not limited to insurance companies, health care service plans, or workers' compensation carriers.

FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she herby individually obligates himself/herself to pay for services, including any balances remaining after all benefits have been paid. Should the account be referred to an attorney or collection, the undersigned will pay actual attorney's fees and collection expenses.

MEDICAL ASSIGNMENT: I certify that the information given by me in applying for payment under Title XVIII of the Social Security act is correct. I request that payment of authorized benefits be made in my behalf.

ASSIGNMENT OF INSURANCE BENEFITS: The undersigned authorizes, whether he/she signs as agent or as patient direct payment to David T. Clawson, MPT and Clawson Physical Therapy of any insurance benefits otherwise payable to or on behalf of the undersigned for all services. It is understood by the undersigned that he/she is financially responsible for charges not covered by this agreement.

I understand that I have the right to a copy of this agreement and waive same unless requested at the time of signing.

The undersigned certifies that he/she has read the foregoing and is the patient, the patient's legal representative, or is fully authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____ **Date**_____

Patient / Guardian / Conservator