PATIENT INFORMATION **WORKERS' COMP.** **DATE:**___________________

(Please Print, Black Ink Only)

Patient Name:________________________ Home Phone: ________________________

Address:________________________ Cell/Pager#:________________________

City & State: ______________ Zip:__________ e-mail: ________________________

Date of Birth: ______________ Sex: M F Marital Status: S M D W Soc. Sec#: ______________

Employer: ________________________ Bus. Phone: ________________________

Address: ______________ City, State: ______________ Zip: __________

Occupation: ________________________

Emergency Contact::________________________ **Telephone**:________________________

Physician's Name: ________________________ UPIN#:__________ NPI#:__________

Address: ______________ City, State: ______________ Zip: __________

Telephone:________________________ Fax:________________________

Insurance:________________________

Address: ______________ City, State: ______________ Zip:__________

Adjuster: ________________________ Case Manager:________________________

Telephone: ________________________ Telephone:________________________

Fax:________________________ Fax:________________________

Date of Injury:______________ Claim#:______________ Diagnosis:______________

Surgery? Yes/No Date of Sx: ______________

Utilization Review:________________________

Telephone: ________________________ Fax:________________________

Who referred patient / How did patient hear of our facility? ________________________

DOCUMENT AUTHORIZATIONS ON COMMUNICATION LOG

NOTES:________________________

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AUTHORIZATION TO PAY CPRx, INCORPORATED

Assignments of Benefits

I hereby authorize my insurance benefits be paid directly to CPRx, Incorporated. I also authorize CPRx, Incorporated to release any information to process this claim.

SIGNED________________________ DATE:______________

Therapist ______________ Appt. Date & Time:______________ Revised December 2007

☐ Ins Coverage Info ☐ Billing Face Sheet ☐ Staffing Sheet ☐ Stamp Charts ☐ New Docs