Advantage Physical Therapy
and Rehabilitation, LLC

Workers' Compensation Questionnaire & Agreement

Patient Name: _____ SS #: _____ DOB: _____

What part(s) of your body did you injure at work? _____

What **DATE** did your injury occur? (BE AS SPECIFIC as possible) _____

WHERE did your injury occur? (BE AS SPECIFIC as possible) _____

_____

HOW did your injury occur? _____

_____

Did anyone witness your injury? ☐ Yes ☐ No If **YES**, who? _____

What **DATE** did you report the incident to your employer? _____

What **DATE** were you first evaluated and/or treated for this medical condition? _____

Have you stopped working as a result of this injury? ☐ Yes ☐ No

If **YES**, Date you stopped working: _____ Are you still off work due to this injury? ☐ Yes ☐ No

Have you ever had a similar medical problem or injury? ☐ Yes ☐ No If **YES**, when? _____

If **YES**, please describe the similar medical problem or injury: _____

Have you received previous treatment for your injury? ☐ Yes ☐ No

If **YES**, please list ANY and ALL sources and dates of treatment below:

Who treated you?	**Date?**

7560 Gardner Park Dr, Gainesville, VA 20155
(703) 753-1005 Phone (703) 753-2207 Fax

9161 Liberia Ave, Ste 205, Manassas, VA 20110
(571) 229-1111 Phone (571) 229-1112 Fax

www.APTRonline.com

Please provide us with the following information:
(You can obtain this information from your employer)

Workers' Compensation Insurer:	
Address:	
Telephone:	
Contact Name:	
Claim No:	

Have you retained an attorney? ☐ Yes ☐ No

If YES, please provide us with the following information

Attorney's Name:	
Address:	
Telephone:	

I testify that my injuries are the direct result of the above mentioned incident. I fully understand that I am responsible for any charges incurred due to the treatment of my medical condition. In addition, I also understand that it is my responsibility to provide *Advantage Physical Therapy and Rehabilitation, LLC* with all necessary information from my employer or other sources in order to file a complete claim. I understand that if the proper and complete information is provided by me, *Advantage Physical Therapy and Rehabilitation, LLC* will make a diligent attempt to retrieve payment for services provided to me from the workers' compensation insurance company **in cases that have been deemed to be covered** by workers' compensation insurance. If my case is not deemed to be covered by workers' compensation insurance, I understand I am expected to follow the guidelines set forth in the Financial Policy form I signed.

By signing this document all terms and conditions provided in this document shall be valid and binding upon me for any present or future services provided to me by *Advantage Physical Therapy and Rehabilitation, LLC* for this condition. I also hereby acknowledge receipt of a copy of this document. I understand I have the right to refuse to sign this agreement and pay for all care at the time of service.

If the undersigned is not the Patient, the undersigned represents and warrants that they have full legal authority to sign this document on behalf of the Patient and understands that they are also responsible for all charges incurred due to services, present and future, provided for the Patient's medical condition.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Copy To Patient By: _____ Date: _____