Form 002

WORKERS COMPENSATION INFORMATION

Today's Date_____

PATIENT INFORMATION

Name_____Birthdate_____ Social Security #_____
Address _____City/State_____ Zip_____
Telephone (home) _____ (work)_____ (cell)_____
EMPLOYER
Employer's Name _____Occupation _____
Employers Address _____ City/State_____ Zip_____
Employers Telephone # _____ Injury verified by_____
Contact Person _____

CARRIER INFORMATION

Workers Compensation Carrier _____Date of Accident_____

Carrier Address _____
Carrier Phone Number_____
Adjuster _____
Claim Number _____

INJURY INFORMATION

Date of Injury _____ Time_____ ☐ AM ☐ PM
Place of Injury _____
Was Accident Reported to Employer? ☐ yes ☐ no Name of person who took accident report _____
How did accident happen?
_____
_____
_____
_____
_____
_____

Have you seen a physician for this condition? ☐ yes ☐ no
Referring Doctor's Name _____Phone#_____
Do you have any previous Workers Compensation Injuries, if yes, please list for the therapist.
_____
_____

AUTHORIZATION

I hereby assign, transfer, and set over to STEVENSVILLE PHYSICAL THERAPY all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature_____Date_____