# WORKERS COMPENSATION INFORMATION

## PATIENT INFORMATION

Name _____ Email _____ Age _____ Sex _____
Address _____ City _____ State _____ Zip _____
Telephone: Home _____ Work _____ Cell _____
D.O.B _____ SSN _____ Marital Status _____
Emergency Contact Person _____ Telephone _____ Relationship _____
Claim Number _____
**Do you have a RN Case Manager?** _____ **Contact Number** _____
**Adjuster's Name** _____ **Contact Number** _____
Employer's Name _____ Occupation _____
Employer's Address _____ City _____ Zip _____

## 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 lost time from work? □ Yes □ No If Yes, How much time have you lost? _____
Did you return to work following the injury? □ Yes □ No Are you currently working at this time? □ Yes □ No
Have you seen another physician for this condition? □ Yes □ No
Doctor's Name _____
Were x-rays taken? □ Yes □ No
Other test? □ Yes □ No If yes, please list test and by whom _____

_____

Do you have any previous Workers Compensation Injuries, if yes, please explain _____

_____

## AUTHORIZATION/ GENERAL CONSENT

reimbursement benefits under my workers compensation policy for physical therapy treatments. 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. In consideration of services rendered, I do hereby agree to guarantee payment of all services not covered by workers compensation. In consideration for other patients receiving physical therapy, I will attempt at least a 24-hour notice if cancellation or re-scheduling is necessary. I understand since this is a worker compensation claim, any cancellations or no-show appointments will be reported to any of the following: Physician, Case worker, Adjustor, Employer. I also understand that 3 or more no-shows or cancellations with less than 24-hour notice could be reason for discharge due to non-compliance.

I have read and fully understand the above general consent form

Patient's Signature _____ Date _____