Worker's Compensation/Auto Accident Information

To be filled out by injured party:

Injured Party's Name: ____________________________ Date of Injury: ____/____/____

SS#: _____-____-_____ Claim#:_____________________

Employer (At time of injury):____
(Required for Worker's Compensation)

Employer Address: ____
Street City State Zip Code

Employer Phone: (____) _____-______

Insurance Carrier Information

Carrier: ____

Claims Mailing Address: ____
Street City State Zip Code

Adjuster's Name: ____

Phone: (____) _____-______ ext. ________ Fax: (____) _____-______

Nurse Case Manager (if applicable) ____

Phone: (____) _____-______ ext. ________ Fax: (____) _____-______

Financial Policy

In the event, that my Workers Compensation claim is denied by the Worker's Compensation Carrier, Advanced Physical Therapy and Fitness will not transfer charges to an attorney lien that were assessed prior to the date the claim was denied. I understand and agree that I become the responsible party and liable for payment of all charges assessed for professional services rendered. I agree to pay any sum due, upon demand. I understand and agree that if it becomes necessary for Advanced Physical Therapy and Fitness to utilize an outside collection agency, or to commence court action, for the collection of any outstanding charges, I will be responsible for the outstanding balance (plus a $35 processing fee), and in addition, attorney fees, court costs and other expenses of litigation.

I have read and understand the financial policy. I do hereby acknowledge that all information on this form is true and factual.

Patient Signature: ____ Date: _________________________