HEIM PHYSICAL THERAPY

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WORKERS' COMPENSATION PATIENT INTAKE FORM

Patient Name: | DOB: | Date:

Street: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

PLEASE NOTE: Failure to provide us with the appropriate claim information requested below and/or failure to file a claim with your insurer will necessitate us requiring payment from you at the time services are rendered.

PATIENT INFORMATION:

Date of Accident/Injury: _____ Time of Accident: _____

Are you currently working: ☐ Yes ☐ No If No, Last Date Worked: _____

Was an automobile involved with your injury: ☐ Yes ☐ No

Job Title: _Produce Manager_____ Job Description: _____

Please provide a brief description of how you were injured:

_____

_____

_____

_____

EMPLOYER INFORMATION:

Employer at time of Injury: Phone:

Employer Address:

Employer Contact Name: Phone:

Are you still employed here: ☐ Yes ☐ No

INSURANCE CLAIMS SHOULD BE SENT TO:

Workers' Compensation Carrier Name:

Address:

Claim #: | Policy #:

Contact Person's Name: Phone:

WCB #:

AUTHORIZATION, ASSIGNMENT AND RELEASE X_____ Date: _____

I hereby authorize payment directly to *Jefferson Sports Physical Therapy d.b.a. Heim Physical Therapy, PC,* for services rendered relating to an accident/injury covered under Workers' Compensation Insurance Benefits. I hereby authorize the provider of these services to release any medical records relating to my claim to my insurer liable for payment of such claim and/or my attorney.

In the event the provider's charges are outstanding and/or I fail to file an application for benefits under New York State Insurance Law or it is determined by the Workers' Compensation Board that my illness or condition is not of a compensable Workers' Compensation Case, I understand that I am personally responsible for the payment of the charges related to my claim.