Family Physical Therapy

7 PARK AVENUE
COLCHESTER, CT 06415
P (860) 531-3222 **F** (860) 531-3224

3 WEYMOUTH RD
ENFIELD, CT 06082
P (860) 698-6308 **F** (860) 698-9658

WORKER'S COMPENSATION INFORMATION

PATIENT INFORMATION

NAME: _____ SS#:_____ DOB: _____

EMPLOYER INFORMATION

EMPLOYER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE NUMBER: _____ FAX NUMBER: _____

INJURY INFORMATION

DATE OF INJURY: _____ BODY PART INJURED: _____

HOW WHERE YOU INJURED?: _____

WORKER'S COMPENSATION INSURANCE INFORMATION

INSURANCE CARRIER: _____

POLICY / CLAIM NUMBER: _____

ADJUSTER'S NAME: _____

PHONE: _____ FAX: _____

ADDRESS (CLAIM SUBMISSION): _____

CITY: _____ STATE: _____ ZIP CODE: _____

ATTORNEY INFORMATION

NAME: _____FIRM NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ FAX: _____

ASSIGNMENT OF BENEFITS AND RELEASE

In addition to the assignment of benefits and release of information clauses that I accepted on the main registration form, I also understand that in the event that services rendered are not covered by this WC carrier, a bill for services rendered will be sent to my insurance carrier for payment. If benefits are not assigned to Family Physical Therapy, I agree to forward to Family Physical Therapy, all "insurance" payments that I receive for services rendered to me immediately upon receipt and/or to make payments, in full, for the series rendered to me at this time.

SIGNATURE: _____ DATE: _____