WORKERS' COMPENSATION INFORMATION

Patient Name:____

Employer Name:____

Employer Address:___________________________City________________State______Zip_______

Employer Phone Number:____

Workers' Comp Carrier:____

Carrier Address:_____________________________CIty_________________State_____Zip________

Carrier Phone Number:____

Case Manager Name:____

Case Manager Phone Number:____

Date of Injury/Accident:_________________________Body Part Involved:_______________________

Carrier Case #:________________________________WCB #:________________________________

Disability Status: Are you currently working? Yes No

____Full Duty ____Light Duty ____Restricted Duty ____Not Working? Date last worked_________

Job Description and Duties:____

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Brief Description of Accident and what treatment you have received thus far:_______________________

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PATIENT TREATMENT WAIVER - WORKERS' COMPENSATION

Thank you for choosing Buffalo-Niagara Physical Therapy for your rehabilitation needs. We look forward to serving you and providing efficient, quality care. Since you have elected to treat with Buffalo-Niagara Physical Therapy for your injury you must be aware of office policy. Should your Workers' Compensation deny your claim, you are responsible for 100% of billed charges.

I, (print name)____understand that the Physical Therapist does not participate with my private insurance, or I do not have private insurance. I understand and am aware of office policy regarding responsibility of medical bills. I have decided I wanted to continue with visits beginning today, and therefore assume responsibility for paying the bill.

Signature____ Date_______________

Insurance Name____

THIS FORM IS VALID FOR THE ENTIRE TREATMENT FOR THIS INJURY