WESTLAKE PHYSICAL THERAPY

WORKERS COMPENSATION & AUTO INJURY CLAIMS

Patient Name: _____ Birthday: _____/_____/_____

BASIC CLAIM INFORMATION

Insurance Name: Auto: _____ Workers Comp: _____

Adjustor/Claim Manager: _____ Phone _____ext_____ Fax:_____

Address: _____City: _____ State: _____ Zip _____

Claim #: _____ Accident Date: _____/_____/_____

Body Part Covered on Claim: _____ Remaining PIP Benefits: $_____

Employed by: _____ Address: _____

Phone Number:_____ Fax:_____

PERSONAL HEALTH INSURANCE INFORMATION

PLEASE FILL OUT INFORMATION BELOW AND GIVE YOUR CARD TO THE FRONT DESK

Insurance Name: _____ ID # _____

Policy Holder Name: _____ Gender: M F Birthday: ____/_____/_____

Your Relationship to Policy Holder: Self Spouse Child Other: _____

ATTORNEY INFORMATION

Name: _____ Law Firm: _____

Address: _____City: _____ State: _____ Zip _____

Phone: _____

I understand that I assume financial responsibility for payment of charges which are not covered by the companies listed above. As a courtesy, my claim will be billed to my accident coverage and personal health insurance company prior to billing my attorney. It is my responsibility to pay any deductible, copay, or any other balance not paid for by my accident coverage.

_____ _____

Signature of Patient or Responsible Party Date

OFFICE USE ONLY:

NOTIFICATION REQUIRED? YES NO LIEN AGREEMENT SIGNED? YES NO _____

DATE