Complete Body Physical Therapy

Worker's Compensation, Motor Vehicle, or Personal Injury

Worker's Compensation

Employer: _____ Telephone: _____

Street:_____ City:_____ State:_____ Zip:_____

Insurance Co: _____ Telephone: _____

Date of Injury: _____ Claim #: _____

Claims Adjuster: _____ Phone:_____ Fax:_____

Claims Mailing: _____ City:_____ State:____ Zip:_____

Motor Vehicle

Insurance Co: _____ Telephone:_____

Date of Accident: _____ State Accident Occurred:_____ Claim#_____

Claims Adjuster: _____ Phone:_____ Fax: _____

Claims Mailing:_____City:_____ State:_____ Zip:_____

Responsible Party: _____ Policy#:_____

Med Pay Limit: _____ Available Benefit: _____

Legal Representation:

Attorney Name: _____ Telephone: _____

Law Office of: _____Fax:_____

Street: _____ City:_____ State:____ Zip:_____

Submit Medical Bills To: _____ Attorney _____ MVA Insurance _____ Worker's Comp

_____ Health Insurance _____ Other: _____

By signing this form, you authorize Complete Body Physical Therapy to furnish your case adjuster and/or attorney with a full report of any evaluations, treatment plans, prognosis, itemized bills, or medical claims etc. By signing this for, you authorize release of necessary health information to the above parties.

Patient Signature: _____Date:_____