WORKERS COMPENSATION / INSURANCE INFORMATION

The following information is needed for all Workers Compensation Claim and Insurance Claim treatments. Please complete the details below:

Name: ____ **DOB:** ________________________

Occupation: ____

Employer: _____________________________ **Phone:** _____________ **Fax:** ____________

Address: ____

Diagnosis/Injury: ____

Date of Injury: ________________ **Date of Recurrence: (If applicable)** __________________

Claim No: ____

Insurance Company: ____

Insurance Company Address: ____

Claims Officer: _________________________ **Phone:** _____________ **Fax:** ____________

Referring Doctor: _______________________ **Phone:** _____________ **Fax:** ____________

Address: ____

Other Treating Specialists: ________________ **Phone:** _____________ **Fax:** ____________

Rehab. Case Manager: ____________________ **Company:** __________________________

Phone: __________________________________ **Fax:** _______________________________

Solicitor: ________________________________ **Phone:** _____________ **Fax:** ___________

Release of Confidential Information / Privacy Act

I authorise HOYS PHYSIOTHERAPY to obtain and release information relevant to my treatment, in verbal or written form, to or from my treating professionals, other treating professionals, insurers, solicitors, unions and employers. The information provided will be of a factual nature concerning the treatment programme and a copy of any relevant written report may be provided.

I understand that I can change or cancel this authority at any time. I have read the HOYS PHYSIOTHERAPY Policy.

Name: __________________________ **Signature:** ________________ **Date:** ___________

Liability of Claim

I understand that in the event of the Insurer denying liability of my Workers' Compensation / Insurance Claim, I will become responsible for the settlement of all outstanding treatment accounts owing to HOYS PHYSIOTHERAPY held in my name. I understand that it is my responsibility to advise HOYS PHYSIOTHERAPY of any changes relating to my Insurance Claim.

Name: _________________________ **Signature:** __________________ **Date:** ___________