PROFORMANCE
PHYSICAL THERAPY

This injury is due to: ☐ Auto Accident ☐ Work-Related ☐ Personal Injury

Our office requires *ALL* information for Worker's Compensation or Accident Liability. If we have received incomplete information or the insurance company denies you will be responsible for the bill.

Worker's Compensation

Supervisor Name_____ Phone _____ Report Filed? ◯Yes ◯No

Case Manager/Adjustor _____Phone_____Fax_____

Claim Number _____ Date of Injury_____

Claim Billing Address _____

Accident/Liability Claim

Personal Insurance Co. _____ Phone _____

Address _____ City _____ State _____ Zip _____

Adjustor _____ Claim Number _____

Third Party Insurance Co. _____ Phone _____

Address _____ City _____ State _____ Zip _____

Adjustor _____ Claim Number _____

Insured's Name _____ Address _____

I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered, regardless of my insurance. I have read the information above and certify that this information is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Signature of patient or parent/guardian if under 19 years of age.