HULST JEPSEN
PHYSICAL THERAPY

Worker's Compensation Disclosure & Authorization Form

I, the undersigned, represent that I have good and sufficient reason to believe the condition for which I am seeking treatment is covered by worker's compensation. I am providing the information below and hereby authorize **Hulst Jepsen Physical Therapy, Inc** and its' attorneys to make further inquire into the status of my claim.

Employer:_____

Employer's Phone Number:_____

Injury Date:_____ Body Part Injured_____

Case Manager:_____ Case Manager Phone:_____

Case Manager Fax:_____ Case Manager Email:_____

Employer's Comp Carrier:_____

Phone Number:_____

Claim Number:_____

I understand that **Hulst Jepsen Physical Therapy, Inc** will waive personal responsibility for any amount due unless it is late found that the condition treated was not work-related, authorized, or if a settlement was reached. If it is determined any amount not covered is due to the above reasons, then I expressly agree to assume responsibility for all amounts due.

_____

SIGNATURE OF PATIENT AND/OR RESPONSIBLE PARTY **DATE**

I agree to the terms presented above and hereby request and authorize **Hulst Jepsen Physical Therapy, Inc** to treat me. I also authorize the release, for medical and/or billing purposes, all information acquired in the course of my treatment.

_____

SIGNATURE OF PATIENT AND/OR RESPONSIBLE PARTY **DATE**