



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 later 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.

By signing below, 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