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.

Claim Number: _____

Employer: _____

Employer's Address: _____

_____

Employer's Phone Number: _____ Injury Date: _____

Body Part Injured: _____

Case Manager: _____ Case Manager Phone:_____

Case Manager Fax:_____ Case Manager Email:_____

Employer's Comp Carrier:_____

Comp Carrier Phone 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**

_____

**PRINTED NAME OF PATIENT AND/OR RESPONSIBLE PARTY**