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: ____

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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.

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

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PRINTED NAME OF PATIENT AND/OR RESPONSIBLE PARTY