ONONDAGA PHYSICAL THERAPY
Helping you live, work and play better

Worker's Compensation & No Fault

(Please Print Clearly)

WORKERS COMPENSATION ONLY

Workers Compensation Carrier	Adjuster's Name	Phone	
Workers Comp. Address	City	State	Zip Code

WCB #	Policy/Claim #	Date Of Injury / /	Employer at time of injury:
Date Last Worked: / /	How Were You Injured?		

Attorney's Name	Firm	Phone	
Attorney's Address	City	State	Zip Code

The above information is true to the best of my knowledge. I authorize my workers compensation benefits to be paid directly to Onondaga Physical Therapy, LLC. I understand that I am financially responsible for any balance left unpaid by workers compensation regardless of reason. I authorize Onondaga Physical Therapy, LLC and my insurance company to release any information required to process my claims.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

NO FAULT ONLY

Insurance Co. Of Car You Were In	Adjuster's Name	Phone	
Insurance Co. Address	City	State	Zip Code

File #	Policy/Claim #	Date Of Accident / /	Location Of Accident
Date Last Worked: / /	History Of Accident		

Attorney's Name	Firm	Phone	
Attorney's Address	City	State	Zip Code

The above information is true to the best of my knowledge. I authorize my No Fault benefits to be paid directly to Onondaga Physical Therapy, LLC. I understand that I am financially responsible for any balance left unpaid by the insurance company regardless of reason. I authorize Onondaga Physical Therapy, LLC and my insurance company to release any information required to process my claims.

X _____

PATIENT/GUARDIAN SIGNATURE DATE