



Worker's Compensation & No Fault

(Please Print Clearly)

WORKERS COMPENSATION ONLY

Workers Compensation Carrier		Adjuster's Name		Phone	Fax
Date of Injury / /		Case Manager's Name		Phone	Fax
Workers Comp. Address			City	State	Zip Code
WCB #	Policy/Claim #	Are you still working?		Date Last Worked: / /	
**Have you had PT for this injury before?	Employer at time of injury	What body part(s) was/were injured in the accident?			
Employer's Address			City	State	Zip Code

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				

WORKERS COMPENSATION and NO FAULT

Attorney's Name (if applicable)		Firm	Phone		
Attorney's Address			City	State	Zip Code

The above information is true to the best of my knowledge. I authorize my 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