NO FAULT/WORKERS COMPENSATION INFORMATION

INSURANCE CO NAME	ADDRESS	PHONE #
CLAIM/CASE #	DATE OF ACCIDENT/INJURY	
CLAIMS ADJUSTER NAME	PHONE#	
ATTORNEY NAME	ADDRESS	PHONE #

CONSENT FOR TREATMENT:

I hereby grant my authorization & consent to such examination(s), treatment(s) as deemed necessary by the therapist(s) at this facility.

Signed: x________________________________ Date: / /

ASSIGNMENT OF BENEFITS:

I authorize payment of benefits to undersigned supplier for services(s) described.

Signed: x________________________________ Date: / /

RELEASE OF INFORMATION:

I authorize the release of any information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signed: x________________________________ Date: / /

I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE, AND THAT I WILL BE RESPONSIBLE FOR PAYMENT OF SERVICES NOT COVERED BY MY INSURANCE COMPANY.

Signed: x________________________________ Date: / /