Worker's Compensation Form

Name: ____

Date of Injury: ____

Name of Employer: ____

Insurance Carrier: ____

Carrie Address: ____

Adjuster's name: ____

Adjuster's number: ____

Claim Number: ____

Have you received medical care from anyone else for this injury? If so, who:

____

____

Describe accident:

____

____

____

Please supply Bodyworks Therapy with a copy of the *Report of Injury* that you and your employer completed copy. Work comp guidelines are strict, it is important that you adhere to your plan of care as it is prescribed. I hereby consent and authorize the Bodyworks Therapy to obtain and release any information to the insurance company, attorney, or referring physician upon request. All valid claims are covered 100% by your employer's work comp insurance carrier and I assign and request payment of medical benefits to Bodyworks Therapy. I understand that I am financially responsible for any charges not covered by my insurance carrier.

Print Name: ____

Patient's Signature: ________________________________Date: ____________

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