Physical Therapy Sports Institute

1515 W. Florida Ave, Ste E
Hemet, CA 92543
Phone: 951.658.3121

Worker Compensation Information

TO BE FILLED OUT BY INJURED WORKER:
(ALL FIELDS REQUIRED)

Injured Worker's Name: _____ Date of Injury: ____ / ____ / _____

Social Security Number: _____ Claim #: _____

Employer (AT TIME OF INJURY): _____ Date: _____

Employer Address: _____
Street Address *City* *ST* *Zip*

Employer Phone: ( ) _____

Worker Compensation Carrier / Attorney Information

Carrier: _____

Claims Mailing Address: _____
Street Address *City* *ST* *Zip*

Adjuster's Name: _____

Ph: ( ) _____ Extension: _____ Fax: ( ) _____

UR/NCM Contact: _____

Ph: ( ) _____ Extension: _____ Fax: ( ) _____

Attorney Name: _____ Phone: ( ) _____

Mailing Address: _____
Street Address *City* *ST* *Zip*

NON-COMPLIANCE NOTIFICATION

Your therapist, physician, adjuster and case manager, work together to assist your return to full function in the workplace. In order for your treatment to have maximal effect and progress, all prescribed therapy sessions must be attended. To comply with the workman's compensation laws, we are required to notify the adjuster, case manager and physician of missed appointments. If for any reason, you are unable to attend, please call in a timely manner and we will reschedule your appointment and inform your adjuster. Missed appointments may result in discontinuation of workers compensation benefits.

I have read and understand the non-compliance notification. I do hereby acknowledge that all information on this form is true and factual.

Patient Signature: _____ Date: _____