HUGHES
Your Bridge to Better Health
PHYSICAL THERAPY

WORKER'S COMPENSATION INFORMATION

Employer at the time of injury? _____

Date of injury/accident? _____

Have you had prior Physical Therapy for **THIS** claim? ( ) YES ( ) NO
If yes, how many? _____

What is your claim number? _____

Who is your claims manager? _____Phone # _____

Who is the administrator? _____
(i.e.: Eberle Vivian, ESD 112, Penser, Sedgwick, Labor and Industries)

ATTORNEY INFORMATION

Do you have an attorney? ( ) Yes ( ) No

If yes, name of attorney: _____

Phone # _____

Please have your attorney contact us as soon as possible regarding your treatment with us.

List your personal health insurance company: _____
(Will be used only if your claim is denied)

We reserve the right to collect a $20 fee for no shows and less than 24-hour late cancellations; this cannot be billed to your insurance company.

I acknowledge the insurance information I have provided is true to the best of my knowledge.

Signature: _____ Date: _____