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Physical Therapy & Wellness of Richmond

INSURANCE INFORMATION

INSURANCE

Primary Insurance Carrier: _____

Name of Insured: _____ Relation to Insured: _____

ID#: _____ Group#: _____

Secondary Insurance Carrier: _____

ID#: _____ Group#: _____

Accident Type: **Not Applicable**

Workman's Compensation

Date of Injury: _____/_____/_____

Date/Time you first sought treatment: _____

Employer at time of injury: _____

Employer Phone: (_____) _____

Employer Address: _____

Worker's Compensation Contact Name: _____

Worker's Compensation Contact Phone: (_____) _____

Claim is: _____Open _____Closed

Auto Accident

Date of Accident: _____/_____/_____

State of Accident: _____

Date/Time you first sought treatment: _____

Litigation Pending: _____Y _____N

Attorney's Name: _____

Attorney's Phone: (_____) _____

I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits.

Signature _____ Date _____

Patient/Guardian

01/2012