We need ALL of the information listed to bill for your therapy visits.

Please complete ALL of this form.

WASATCH PEAK
PHYSICAL THERAPY
at Davis Hospital & Syracuse

Worker's Compensation Liability Form

It is the patient's responsibility to gather this information and return it to Wasatch Peak Physical Therapy within 4 days from the date of service.

If this form is not returned to Wasatch Peak, the patient will be responsible for all charges. If there are unusual Circumstances please contact Wasatch Peak so arrangements can be made. Thank you.

Patient Name _____ Date of Injury _____

Employer Information

Employer Name (on date of injury) _____

Employer's Address _____

City _____ State _____ Zip _____

Employer's Telephone Number ( ) _____

Were you a PART-TIME or FULL-TIME employee? _____

Employer's Worker's Compensation Insurance Company Information

Employer's Workers Comp Carrier Name _____

Address _____

City _____ State _____ Zip _____

Telephone Number ( ) _____ Ext _____ Fax # _____

Contact Person _____ Claim # _____

We realize the above insurance information is in regards to a workers compensation claim. However, if the above entity denies your claim, we will need to have your personal health insurance to bill. Still, some personal health insurances require we have prior authorization for your therapy visits. Thererfore, if you choose not to give us your personal health insurance at this time, and the above listed entity denies payment, and your personal health insurance requires prior authorization that we were unable to receive, you will be responsible for payment. To avoid any problems, please give your personal health insurance information along with the above information. By signing below, you indicate that you understand this information. Thank you.

Patient Signature _____ Date _____