



WORKERS INSURANCE
INFORMATION FORM

www.allstarfitness.com

PATIENT NAME:		DATE:	
ADDRESS:	CITY:	STATE:	ZIP:
CELL#:	HOME #:	WORK#:	DATE OF BIRTH:
SS#:	DATE OF INJURY:	REFERRING DOCTOR:	

PLEASE COMPLETE ALL OF THE FOLLOWING:

CLAIM NUMBER:	ADJUSTER NAME:		
PHONE#:	INSURANCE COMPANY NAME:		
ADDRESS (if other than was state dept of labor & ind.):	CITY:	STATE:	ZIP:
DATE CLAIMED OPENED:			
EMPLOYER:	PHONE#:		
ATTENDING PHYSICIAN:	PHONE#:		
ADDRESS:	CITY:	STATE:	ZIP:
HAVE YOU HAD ANY MASSAGE THERAPY FOR THE INJURY? <input type="checkbox"/> NO <input type="checkbox"/> YES. If YES, # of sessions? _____			

PLEASE READ AND SIGN BELOW.:

In fairness to our other patients and to us, 24 hour notice is required for cancellation of an appointment, or you will be charged in full for the time booked.

Once your insurance coverage has been verified, we will be glad to bill directly to and accept payment from the insurance company. It should be understood that all services are charged to you, the patient, who is legally responsible for payment. Patient agrees to pay all collection costs including, but not limited to reasonable attorney fees, late charges and litigation costs in the event of any breach, including failure to timely make any required payments.

I hereby authorize the release of my medical records to the above insurance company for the express purpose of payment for my medical bills incurred in this office.

I hereby authorize the insurance company or attorney to remit payment directly to this office.

SIGNATURE: PATIENT/PARENT/GUARDIAN	DATE:
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