Injury Information Form

M.V.A. _____ **Workers Compensation _____**

Name: _____

Date of Birth: _____ SS# _____

Date of Accident/Injury_____

Employer: _____

Are you Currently Working? Yes_____ No _____ Last Day of Work_____

Workers Comp. Carrier/P.I.P_____
Address: _____
Phone Number: _____
Adjuster: _____
Claim Number: _____

Medical Insurance: _____
Policy Number: _____Group #_____

Attorney: _____
Address: _____
Phone: _____

If benefits are exhausted, we will bill your medical insurance for payment **IF** all referrals and authorizations have been approved prior to visits. Otherwise payment is your responsibility.

_____
Signature

Date:_____

IRREVOCABLE PRIORITY OF ASSIGNMENT OF INSURANCE

I, _____, do hereby irrevocably assign any and all of my insurance benefits and any and all insurance benefits available to me, to specifically include any Personal Injury Protection benefits and any Medical Pay benefits to **Gold Medal Physical Therapy, LLC** for injuries I have received and sustained on _____ and, further instruct any insurance company and their insurance benefits to be withheld from any other providers until all of the bills from **Gold Medal Physical Therapy, LLC** have been paid in full first. This includes any and all benefits that I may be entitled to receive for lost wages. I further instruct any insurance company and their employees and adjusters to make any and all check payable solely to **Gold Medal Physical Therapy, LLC,** and to mail any and all checks to **407 E. Churchville Road, Suite 102, Bel Air, Maryland 21014,** directly.

This assignment of Insurance Benefits and Priority of Payment of Insurance Benefits is irrevocable and may not be modified, changed, or cancelled.

_____ _____

DATE PATIENT