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:____________________

<u>IRREVOCABLE PRIORITY OF ASSIGNMENT OF INSURANCE</u>

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