Please Complete the Following Information about your Injury (ONLY IF APPLICABLE):

If Auto: *Date of Accident _____ Has Fault Been Established?* Yours _____ Other _____

At-Fault Auto or Your Auto Insurance Company _____

Adjuster: _____ Phone Number _____

Policy Holder's Name _____ Claim Number _____

Do you or the other party have MEDPAY? _____

Do you have an Attorney? _____ May we have permission to speak with him/her regarding your treatment and payment at Healthcore Physical Therapy.? Yes _____ No_____

If Yes, Name _____ Phone Number_____

If Workers Comp: *Date of Injury _____ Claim #: _____*