Fredonia
PHYSICAL
THERAPY
PLLC

12 BRIGHAM ROAD
FREDONIA, NEW YORK 14063
716-679-7447
FAX 716-679-7446

WORKERS' COMPENSATION PATIENTS

Welcome to **Fredonia Physical Therapy**. We thank you and your physician for choosing our practice.

In accordance with the New York State Workers' Compensation guidelines, we are required to obtain authorization prior to your initial visit and reauthorization if treatment continues for 12 visits or 45 days, whichever comes first. If at anytime there is a problem with the authorization process, you will be notified.

AGREEMENT TO PAY MEDICAL COST IN THE EVENT OF FAILURE TO PROSECUTE OR IF COMPENSATION CLAIMS IS DISALLOWED

WCB#____________________

CARRIER CASE#____________________

DATE OF INJURY____________________

SOCIAL SECURITY #____________________

In the event I fail to prosecute Workers' Compensation for this illness or condition or it is determined by the Workers' Compensation Board that the illness or condition is not a result of a compensable Workers' Compensation claim,
*I ____________________________ herby agree to pay **Fredonia Physical Therapy** their usual customary fees for services rendered.*

SIGNATURE____________________________ **DATE**__________

If signed by other than the claimant, print below: name, address and relationship to signer.

____

(Name and Address) (Relationship)