physiomobility HEALTH GROUP
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WSIB INTAKE FORM

Patient ID: _____ (For Office Use)

Last Name: _____ First Name: _____

Date of Birth (mm/dd/yyyy): _____

Date of Accident (mm/dd/yyyy): _____ Claim #: _____

Employer Name: _____

Employer Address: _____

Supervisor / Contact Name: _____

Phone #: _____

Patient's Current Job Title: _____

Length of Time in Current Job: _____ (mm/yyyy)

Adjudicator: _____

Phone #: _____ Fax #: _____

Case Nurse Manager: _____

Phone #: _____ Fax #: _____

LEGAL REPRESENTATIVE

Company: _____

Legal Representative`s Name: _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Phone #: _____ Fax #: _____

E-mail: _____

- ✓ I hereby authorize Physiomobility to collect and release medical records and other information related to my claim to the above mentioned legal representative, my medical doctor and WSIB.
- ✓ I understand that I am legally responsible for providing Physiomobility with all information for my claim including any updates.
- ✓ WSIB will pay a standard fee for medical services related to your approved claim & requires a minimum number of treatment sessions based on applicable program of care.

In the event of denial of your claim or non-compliance with the treatment plan causing your claim to disqualify, WSIB will contact you not the clinic. It will be your responsibility to inform Physiomobility of such decision. I understand that I am responsible for all unpaid fees.

- ✓ I direct all third party payers including WSIB to pay Physiomobility directly for fees related to services provided for my injuries related to this claim.

Patient's Name: _____

Patient/ Guardian's Signature (Printed name serves as signature): _____

Date: _____

Clear **Save** **Print**