Premier Care Physiotherapy

11685 Yonge St. Unit A106 Tel: 905-237-7174
Richmond Hill, ON L4E 0K7 Fax:905-237-7184

Patient ID:_____

Date: _____

WSIB INTAKE

_____ _____ D.O.B:____ /____ /_____
Last name First name

Date of Accident: (D/M/Y): _____ /_____ /_____ Claim #: _____

Employer Name:_____

Employer Address: _____

Supervisor/Contact Name:_____ Phone:_____

Patient's current job title: _____ Length of time in current job:_____

Adjudicator:_____ Phone: _____

Fax: _____

Case Nurse Manager:_____ Phone: _____

Fax: _____

LEGAL REPESENTATIVE

Company: _____ Legal Representative`s Name: _____

Address: _____ City: _____ Province: _____

Postal Code: _____ Phone: _____

Fax: _____

- ✧ I hereby authorize Premier Care Physiotherapy 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 Premier Care Physiotherapy with all information for my claim including any updates.
- ✧ WSIB will pay a standard fee for medical services related to your approved claim. In the event of denial of your claim, WSIB will contact you, not the clinic. It will be your responsibility to inform Premier Care Physiotherapy of such decision, otherwise you will be responsible for all unpaid fees.
- ✧ I direct all third party payers to pay Premier Care Physiotherapy directly for fees related to services provided for my injuries related to this claim.

_____ _____
Patient's name *(please print)* Patient's signature