Resilient Care
Physical Therapy
Quality hands that care for you.

WORKERS' COMP INFORMATION

Name:____

Date of Birth:____________________ Age: ____________________

Social Security #: __________________ Phone: ____________________

Address: ____

Date of Injury:____________________ Time of Injury ____________________

Address where injury occurred:________________________________

Dates out of work: ____________________________________

How did this injury occur? __________________________________

____

Are you currently working? ☐ Yes ☐ No

Are you working ☐ full or ☐ limited duty?

List number of days and dates missed: ____________________________

Employer at the time of injury:______________________________

Employer's Address: __________________________________

____

Employer's Phone Number: ______________________________

Carrier: ____

Address: ____

Phone Number: ______________________________________

Case Manager: ______________________________________

Phone Number: ____________________ Fax Number:____________________

Carrier Case Number if known: ______________________________

WCB Case Number:____________________________________

NOTICE OF PHYSICIAN'S LIEN AGAINST PATIENT'S NET SHARE OF PROCEEDS OF RECOVERY FROM LITIGATION (LIEN/WC)

I, _________________________, hereby authorize my attorneys, _______________________, to pay directly to RESILIENT CARE PHYSICAL THERAPY such sums as may be due and owing to said physician for the value of medical services rendered to me by reason of the injuries sustained by me on __________________ in an accident at ____ and by reason of any other medical monetary recovery that may be obtained on account of third-party litigation arising from the said occurrence of _______________________________________. I hereby recognize and acknowledge a medical lien in favor of said physician against my share of proceeds that may be recovered by my attorneys.

I fully understand that I am directly and fully responsible to RESILIENT CARE PHYSICAL THERAPY for the payment of the value of all medical services and treatment rendered to me and that this **NOTICE** is executed solely for the additional protection of the said physician and in consideration of his forbearance in seeking immediate payment. I further understand that my obligation for payment of the value of my physician's medical services is not contingent on the successful outcome of any litigation arising from the occurrence of ____.

________________ Date

______________________________ Patient's Signature

______________________________ Patient's Printed Name

The undersigned, attorneys for _________________ do hereby agree to observe all terms of the above **NOTICE OF PHYSICIAN'S LIEN** and agree to withhold from the net share of any monetary recovery obtained for _______________ arising from the occurrence of __________________, such as may be necessary to satisfy outstanding billing statements for the value of the medical services and treatment rendered by RESILIENT CARE PHYSICAL THERAPY to _____________ up to the time of the recovery of the said monetary award.

CONSENTED TO AND AGREED:

MARIA MORCILIA, PT

Resilient Care Physical Therapy
57-18 Woodside Avenue, Suite 6102,
Woodside, New York 11377

____
Attorney by Law

____
Date