AGREEMENT TO PAY MEDICAL COSTS IN THE EVENTS OF FAILURE TO PROSECUTE OR IF COMPENSATION CLAIM IS DISALLOWED

WCB Case No. (if known)	Carrier Case # (if known)	Date of Injury	Nature of Injury or Illness	Claimant's SS#
Claimant	Name		Address	Apt #
Employer				
Insurance Carrier				

IN THE EVENT I FAIL TO PROSECUTE THE CLAIM FOR WORKER'S 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 CASE, I, _____
Hereby agree to pay Function Better PT (address) _____
Their usual and customary fees for services rendered to the above named claimant in the above-identified case.

Date _____ Signature _____

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

_____ _____
Name and address Relationship

FILL THIS SHEET OUT ONLY IF WORKER'S COMP!