Failure to complete this form in its entirety will result in being a self-pay patient

WORKERS COMPENSATION

Name _____ Date _____

Your Employer's Information

Name of Company _____

Address _____

City _____ State _____ Zip _____

Employer Contact _____

Employer Phone Number: ( ) _____

Workers Comp Insurance Carrier

Name of Company _____

Address _____

City _____ State _____ Zip _____

Adjuster's Name _____

Adjuster's Phone Number: ( ) _____

Date of injury: (Month,Day, Year) _____ / _____ / _____

What part of the body: _____

Claim Number:

All Workers compensation and disability cases: It is your responsibility to ask for a disability slip after each visit for you to forward to your employer

When claiming an "on the job" injury, please complete the above information in full prior to being seen by the doctor today and sign below for us to be able to submit this directly to your workers compensation carrier. Without full completion of this form, payment will be required at the time of service. If the worker's compensation carrier denies or does not pay this claim, the patient is responsible for payment in full within 30 days.

Signature _____ Date _____