WORKERS' COMPENSATION

All Workers' Compensation Patient's are seen for consultation and/or testing at the request of the treating Work Comp physician. **Your visit must be authorized prior to your appointment by your Work Comp insurance carrier,** or you will be responsible for payment. If any further testing is recommended by our office we will be responsible for getting authorization, or we will refer back to the treating work comp physician.

***PHOTO I.D. IS REQUIRED AT TIME OF VISIT OR APPOINTMENT WILL BE RESCHEDULED*.**

PLEASE SUPPLY ALL THE INFORMATION REQUESTED.

Date of Injury: ____/____/____ **Claim #**:_____

Type of Injury/Body part affected: _____

Did you lose consciousness? YES NO For how long? : _____

How did the injury occur? : _____

_____

What symptoms are you experiencing? : _____

_____

Name of Insurance Carrier: _____

Insurance Co. Billing Address: _____

Adjusters Name: _____ **Phone #:** _____

Nurse Case Manager Name: _____ **Phone #:**_____

Employer at the time of accident: _____

Employer address: _____

_____

SIGNATURE **DATE**