WORKER'S COMPENSATION

Date: ____/____/_____

Patient's Name: _____ Date of Birth: ____/____/_____

Social Security #: _____-____-_____ Home Phone #: (____) _____-_____

Patient's Address: _____

Date of Accident: ____/____/_____
Have you reported accident to employer? Yes __ No __

Describe how accident happened: _____

_____

_____

_____

Employer/Company Name: _____

Employer's Address: _____

City, State, Zip: _____

Employer Contact: _____ Telephone #: (____) ____-_____

Compensation Insurance Co.: _____

Insurance Address: _____

City, State, Zip: _____

Agent: _____ Telephone #: (____) ____-_____

Carrier Case #: _____ WCB Case #: _____

Have you ever been treated by another physician for this injury? Yes ___ No ___

Physician's Name: _____

If this is a prior compensation case that is being treated by another physician, you will be responsible for today's bill unless prior approval has been granted by compensation.

When you receive notification from your insurance company, please give us the insurance carrier case number and other pertinent information from that written correspondence these numbers for us in proper submission of your claim.

AUTHORIZATION AND AGREEMENT

Name: _____ Date of Accident: ____/____/_____

I hereby authorize Middletown Medical, P.C. to furnish my attorney copies of medical reports, bills, and any other pertinent data that pertains to my condition resulting from the injuries sustained on the mentioned date of the accident.

I hereby authorize and direct my attorney to withhold the amount of the physician's bill from any moneys collected on my behalf, and forwarded to the said physician before or on settlement of my case. I understand that this does not relieve me of my obligation to pay the physician's bill and any other bills relating to this care. This assignment is irrevocable.

In the event my compensation claim is denied for payment, I understand that I will be responsible for any and all charges incurred.

In the event I fail to prosecute the claim for Worker's Compensation for this condition or illness or it is determined by the Worker's Compensation board that the condition or illness is not a result of a Worker's Compensation case, I hereby agree to pay Middletown Medical, P.C., 111 Maltese Drive, Middletown, NY 10940 his or her usual an customary fees for services rendered in the above identified case.

If signed by someone other than the claimant, print below:
(Name, address and relationship of the signer)

Name: _____

Address: _____

Relationship: _____

Witness: _____

Signature: _____

Name: _____ Date Signed: ____/____/_____