WORKERS' COMPENSATION FORM

WORK RELATED INJURY INFORMATION

- Has injury been reported to immediate supervisor or foreman? Yes ☐ NO ☐
- If yes, Give his or her name: _____
- May I call your employer for authorization to treat you? Yes: ☐ NO ☐
- Have you retained a Workers' Comp. attorney for this case? Yes: ☐ NO ☐
- Date and time this injury occurred: Date_____Time _____
- Area that you felt pain immediately after the accident _____
- Did you return to work? Yes ☐ NO ☐ Same Company? Yes: ☐ NO ☐
- If not currently working give last date of employment: _____
- Have you ever injured this area before? Yes:☐ NO ☐
- Did you lose time from work at that time? Yes:☐ NO ☐
- Do any other medical problems affect your employment? Yes:☐ NO ☐
- During daily work or activities, do you have to favor any part of your body? Yes ☐ NO☐
- Explain:_____
  _____
- Have you ever had a Workers' Compensation claim before? Yes: ☐ NO ☐
- Since the injury, symptoms are: Improving? ☐ Worse? ☐ Same? ☐ Changing? ☐
- Please Explain:_____
  _____
  _____
  _____

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- Explain in detail how your accident happened? _____

  _____

- Any Other Comments about your injury or treatment you have received that you wish to add:

  _____

  _____

  _____

  _____

Patient Please Read & Sign Below:

"I understand that once I am an authorized Workers' Compensation Patient, I am not to be billed, by you, your staff, or facility, for services, under any circumstances. The only exception is, unless I am required by law to pay a co-pay after reaching MMI, or unless I, or you are notified by the employer/carrier, through legal avenues that you have been de-authorized.

I understand that it is my responsibility to keep all of my appointments with you. I understand also that if I do not, and if I regularly miss appointments, it is then your obligation to notify the employer/carrier & my physician. To regularly or often miss my scheduled appointments is an indication that I may no longer need treatments & can therefore possibly jeopardize my case."

I agree to keep accurate records of travel to and from your facility for medical treatment because I may be able to receive travel reimbursement that may be required by my State's Workers' Compensation law.

Signed: _____ Date: _____