

# The Neurology Group, LLP

## WORKER'S COMPENSATION INFORMATION

(To be filled out at first visit for Worker's Compensation injury)

### GENERAL INFORMATION

**ALL EMPLOYER INFORMATION IS TO BE COMPLETED BASED ON \* THE TIME OF INJURY \***

Patient's Name: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer City/State: \_\_\_\_\_ Employer Zip: \_\_\_\_\_

Job Title \_\_\_\_\_ Job Description \_\_\_\_\_

### WORKER'S COMPENSATION INSURANCE INFORMATION

(This information must be filled out. If not, balance owed will be billed to patient.)

Have you reported your injury to your employer? YES ( ) NO ( )

Contact person at your employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Worker's Comp Insurance Carrier: \_\_\_\_\_

WC Carrier Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone : ( ) \_\_\_\_\_ - \_\_\_\_\_ WCB # \_\_\_\_\_ Carrier Case# \_\_\_\_\_

### INJURY INFORMATION

Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_ Date of Hearing: \_\_\_\_\_

Address where injury occurred: \_\_\_\_\_

If you were hospitalized, please give dates and name of hospital: \_\_\_\_\_

Briefly describe the accident and your injury: \_\_\_\_\_

Are you out of work? ( **must be answered** ) YES ( ) NO ( ) Date last work: \_\_\_\_\_

### AUTHORIZATION

I authorized The Neurology Group, LLP to release all records pertaining to medical history, services rendered or treatment to my dependent (or me) for insurance claims. I authorize payment of medical benefits to The Neurology Group, LLP. I recognize that I am responsible for all payments not covered for the medical service disputed or denied by my insurance carrier or employer's Worker's Compensation Insurance Carrier.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_