WORKMAN'S COMPENSATION

Please Print

PATIENT'S NAME: ________________________ DATE OF BIRTH: ______________________

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Employer: ____

Address: ____

Phone Number: ____________________________ Supervisor: _________________________

Worker's Compensation Insurance Carrier: ____

Address: ____

Claim Number: ___________________________ Adjuster Name: ________________________

Phone Number: __________________________ Date of Accident: ________________________

Was this injury reported? ___ NO ___ YES If yes, to whom: _______________________

Briefly describe the accident and injuries: ____

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If you have an attorney, please provide name, address and telephone number: (This is for our chart information only; we will not bill your attorney for services rendered.)

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I understand that Delaware Neurosurgical Group, P.A., as a certified Workman's Compensation provider for the State of Delaware, is entitled to be paid for services rendered at the full published Delaware Workman's Compensation fee schedule in effect on the date(s) of service. In the event of a legal settlement, I agree that any "paid" health insurance claim will subrogate back to my health insurance provider. All balances due to Delaware Neurosurgical Group, P.A. for services performed will be billed to and paid by my legal representative in accordance with the applicable Workman's Compensation fee schedule, regardless of the amount paid by my health insurance provider or any adjustments made to payments based on contractual agreements with my health insurance provider.

In the event my claims are denied by the above listed insurance carrier, I understand my personal health insurance will be billed. Therefore, for my protection, I will obtain the necessary referrals if applicable. I understand that I am responsible for any payment of all services rendered should my claims be denied.

SIGNATURE: ______________________________ DATE: ____________________________

Electronically Signed (if applicable)