Highland Medical, P.C.

WORKER'S COMPENSATION PATIENT INTAKE FORM

patient name | date of birth | social security number

street address | city/state/zip

home phone | cell | work

Please Note: Failure to provide us with the appropriate claim information requested below and/or failure to file a claim with your insurer will necessitate us requiring payment from you at the time that services are rendered.

PLEASE PROVIDE THIS INFORMATION WITHIN TWO BUSINESS DAYS

AUTHORIZATION:

I hereby authorize payment directly to Highland Medical, PC for services rendered relating to an accident/injury/exposure covered under Workers Compensation Insurance Benefits. I hereby authorize the provider of these services to release any medical records relating to my claim to my insurer liable for payment of such claim.

In the event the provider's charges are outstanding and/or I fail to file an application for benefits under New York State Insurance Law, I understand that I am personally responsible for the payment of the charges related to my claim.

date of injury | time of injury

address where injury occurred | city/state/zip

employer name | employer phone

employer address | city/state/zip

How Injury Occurred: ______________________________

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claim number | policy number | policy holder's name

Have you missed any time from work?: ______________________________

Highland Medical, P.C.

NAME AND ADDRESS OF WHERE THE INSURANCE CLAIMS SHOULD BE SENT:

(NOT YOUR AGENT'S NAME AND ADDRESS)

insurance company name | phone | contact name

street address | city/state/zip

patient signature | date