# 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, if not already given? Yes ❑ No ❑
- Have you retain a Worker's 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 day 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 Worker's Compensation claim before? Yes ❑ No ❑
- Since the injury, symptoms are: Improving ❑ Worse ❑ Same ❑ Changing ❑
  - If changing, explain: _____________________________________________________
- Explain in detail how your accident happened? ____________________________________

  ___________________________________________________________________________

  ___________________________________________________________________________

**Patient: Read & Sign Below**:

"I understand that once I am an unauthorized 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 authorized. I understand that it 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."

Signed: __________________________________________ Date: ___________________