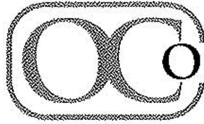

Workers Compensation Registration Form Patient# ____________

Date:________ Intake Person:__________ DOI:________ pt Verified Y/N Initials

Treating Physician:________________ Appt Date:________ Appt Time:_____

Appt Location: _____ Lake Worth _______ Boynton Beach

****
Claimants Name:______________________________ Sex: M F

Marital Status: _________________________

Tel # Home:______________ Work:______________ Cell:__________

Address:____

City:________________ State: ________ Zip: ____________

****
Diagnosis:_________________________ Body Part:______________

SS#:________________ DOB:__________ Translator Needed Y / N

W/C Claim Number:______________________________

****
Employers Name at time of injury:______________________________

Address:________________________________ Phone:__________

City/State:________________________________ Zip:__________

****
Referral Source:

Date Referral Initiated:__________________

Company Name:______________________ (i.e. Liberty, Summit, Corvel, etc)

NCM/Adjustor/Employer:____________________________________

Phone#:__________________ Ext:__________ Fax:______________

E-Mail:____________________________

Is there a NCM/Adjustor on the case (other than the above named individual) Y / N

Name:__________________ Co:______________ Phone:__________

Fax:________________________ E-Mail:____________________

BILLING INFORMATION: Insurance Company: ____________________________

Network: ____________________________

Address: ____

Phone: ____________________ Fax: ____________________

Emergency Contact:

In case of emergency whom may we contact? ____________________________

Phone: ____________________________

Is there an Attorney involved on the case? Y / N

Name of Attorney: ____________________ Phone: ____________________

Address: ____

Assignment of Insurance Benefits: I hereby authorize payment directly to the Orthopedic Center of Palm Beach County, (hereinafter referred to "OCPBC") and assign to them any and all rights and benefits that I or the patient may have under any policy of insurance including medical, automobile, personal injury protection, workers compensation, or any other coverage and further direct any such insurance company to make payment of benefits directly to OCPBC. I understand I am financially responsible to OCPBC for charges not covered by this agreement.

__________ Initial __________ Date

Lifetime Signature Authorization: I hereby authorize OCPBC to furnish to my insurance company or their representative, or Social Secur8ity Administration or the Center for Medicare and Medicaid, or Medigap or its intermediaries or to the billing agent of OCPBC any information needed for this claim or related claims. I permit a copy of this authorization to be used in place of the original.

__________ Initial __________ Date Notice of Privacy Practice: I have been provided information by the OCPBC regarding their privacy practices.

Patient signature: ____________________________ Date: __________

Responsible party signature: ____________________________

Relationship to patient ____________________________ Date: __________

I UNDERSTAND IF THIS IS NOT COVERED BY WORKERS COMPENSATION I ACCEPT RESPONSIBILITY FOR PAYMENT

Patient signature: ____________________________ Date: __________

Responsible party signature: ____________________________ Date: __________

Relationship to patient: ____________________________ Date: __________

IF PATIENT IS UNDER AGE 18, I HEREBY GIVE MY PERMISSION FOR:

____________________ TO BE TREATED BY OCPBC: ____________________

__________ ____________________ ____________________

Date Signature Witness