CAPITAL IMAGING, LLC

WORKERS COMPENSATION INFORMATION FORM

You have indicated that your injury was work related. Before a Workers Compensation Claim can be filed on your behalf, we MUST have the following information immediately. If you did not come with this information, please make arrangements with the receptionist to contact your employer. This information must be obtained before your scheduled appointment time today. In the event that you miss your scheduled time, but do receive this information and the doctor is still here, every effort will be made to see you sometime during patient hours. However, if you are unable to obtain this information, it will be necessary for you to reschedule your appointment.

Employers Name: _____

Address: _____

City, State, Zip: _____

Supervisor or Contact Person: _____ Phone: _____

Date of Injury: _____/_____/_____ Time: _____

Has a first report of injury been filed? Y N Did you bring a copy? Y N

Name of Comp Carrier: _____

Complete Address: _____

City, State, Zip: _____

Claim/Case Number: _____ Authorization #: _____

Adjuster Name: _____ Phone: _____

Describe what happed to cause your injury: _____
_____
_____

I authorize ***Capital Imaging, LLC*** to apply for benefits on my behalf for all services rendered. I further authorize the release of all medical information necessary to process my claims. I understand that in the event that my Workers Compensation claim is denied or I fail to obtain all of the necessary information, I will be fully responsible for all payments. I permit a copy of this authorization to be used in place of the original. If it is necessary to turn this account over to a collection agency/attorney, I agree to pay all reasonable costs of collections, attorney fees and a one time service charge of 25% of the balance due.

_____ _____ _____
Patient Signature Print Name Date

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