510 Hamburg Turnpike, Suite 101, Wayne, NJ 07470
Phone: 973.942.6005 Fax: 973.942.6009

WORKERS COMPENSATION INFORMATION FORM

(Please Print)

Today's Date: 6/29/2012				FOR OFFICE USE - PCP:
PATIENT INFORMATION				
Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Home phone no.: ( ) Cell phone no.: ( )	
Occupation:	Social Security no.:			
EMPLOYER INFORMATION				
Employer's Name:				
Employers Street Address:				
P.O. box:	City:	State:	ZIP Code:	
Employer Contact Last Name: First:	Employer phone no.: ( )			
Workers Compensation Carrier:	Authorization # for Todays Visit:			
Workers Compensation Claim #:	Workers Compensation Claim #:			
Date of Incident:				
Injury Details:				

I HERE BY AUTHORIZE, ALLIED MEDICAL ASSOIATES TO FURNISH INFORMATION TO THE WORKMANS COMPENSATION INSURANCE CARRIER LISTED ABOVE CONCERNING MY INJURYAND TREATMENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE CARRIER. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY PAYMENT AT THE TIME OF THE VISIT. I UNDERSTAND THAT THE FEES SET BY THIS OFFICE MAY EXCEED WHAT MY INSURANCE CARRIER CONSIDERS TO BE REASONABLE AND CUSTOMARY CHARGES FOR THIS AREA. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT IN FULL REGARDLESS OF THE DECISION MADE BY MY INSURANCE CARRIER.

I have read the above information, understand it completely and agree to its terms.

Print Name	*Patient/Guardian signature*	*Date*