OSTERBERG Chiropractic Centre

Worker Compensation Information

Patient Information

Name:_____ DOB: _____ SSN: _____

Employer Information

Employer Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer Ph: _____ Contact Person: _____

Is Osterberg Chiropractic Centre on your employer approved worker compensation panel? Yes / No

Worker Compensation Carrier Information

Carrier Name: _____

Address to submit claim: _____

City: _____ State: _____ Zip: _____ Carrier Ph: _____

Adjuster Name: _____ Adjuster Ph: _____

Claim #: _____

Injury Information

Date of Injury: _____ Time of Injury: _____am / pm

Place of Injury: _____

Was accident reported to employer? Yes / No Name of person reported to: _____

Give full description of how accident happened: _____

_____

_____

_____

_____

Have you lost time from work? Yes / No If so, how much time? _____

Any previous worker compensation injuries? Yes / No Dates: _____

If so, describe previous worker compensation injuries: _____

_____

Authorization

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Worker Compensation benefits is denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges.

_____ _____

Signature of Patient (or Parent/Legal Guardian/ Personal Representative) *Date*

_____ _____

Print name of Patient (or Parent/Legal Guardian/ Personal Representative) *Relationship to Patient*