

WORKERS COMPENSATION AGREEMENT

Patient Name _____

Address _____

Telephone Number: Home _____ Work _____

Date Of Birth _____ Social Security # _____

Date Of Injury _____ State That Injury Occurred In _____

Employer _____

Employer's Address _____

Person to contact at employer's for information relating to injury and employment

Employer's Insurance Carrier and Address

Insurance Group or Policy Number:

Description of how the injury occurred and where:

Time Occurred: _____

Is this the first time one of our physicians has seen you for this injury?

If not, explain:

Did you go to Saint Elizabeth's Emergency Room? _____

As a courtesy to you, the **Saint Elizabeth Physician Resource Network** will file the Workers Compensation claim with the State and your employer as stated above on this agreement, and any subsequent work related claims that we are advised of. In the event it is determined by the Workers Compensation Board that the illness or condition stated above is not a result of a qualified Workers Compensation case, I do hereby agree to pay for the services rendered.

I hereby authorize my physician to release any and all medical records to the Workers Compensation Court, insurance carrier, and my employer.

Date _____ Signature _____