Be Truly Well Chiropractic & Day Spa
WORKER COMPENSATION INFORMATION

Patient's Name_____ Date_____

Employer

Employer Name_____
Employer Address_____
Employer Phone(____)_____ Email _____
Injury verified by (For office use)_____
Contact Person_____

Worker Compensation Carrier (For Office Use)

Worker Compensation Carrier_____
Carrier Address_____
Carrier Phone (____)_____ Coverage Verified by_____
Adjuster's Name_____ Claim Number _____
Attorney's Name_____
Attorney's Address_____

Injury Information

Date of injury_____ Time_____☿ am ☿ pm Place of injury_____ Was the incident reported to a supervisor? ☿ Yes ☿ No Name of person you reported accident to _____ Describe the incident._____

Have you lost time from work? ☿ Yes • No How much?_____
Were you sent to see a doctor? ☿ Yes ☿ No Other doctors seen for this condition:
Doctor's name_____ Diagnosis _____ Were X-rays taken? ☿ Yes • No Other Tests? ☿ Yes ☿ No If Yes, by whom? Please list test(s) and result(s)_____

Are there problems that effect work? What?_____ Do you favor 1 side in work? ☿ Yes ☿ No If so, which side?_____ Before the injury did you do work equally to others your age? ☿ Yes ☿ No Any previous Worker Compensation injuries? ☿ Yes ☿ No Date(s) of previous injuries_____ 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, Parent, Guardian or Personal Representative Date

Please print name of Patient, Parent, Guardian or Personal Repres. Relationship to Patient