ORTHOPEDIC SURGICAL PARTNERS
ORTHO SPEED PASS

Workers' Compensation Information

PATIENT NAME: _____

DATE OF INJURY:_____**BODY PART:** _____

EMPLOYER: _____

EMPLOYER CONTACT PERSON:_____**PHONE:**_____

WAS THIS INJURY REPORTED TO YOUR EMPLOYER? Y / N

WORKERS' COMP INSURANCE CARRIER NAME: _____

ADDRESS: _____

CLAIM NUMBER: _____**CASE WORKER NAME:** _____

PHONE: _____**FAX:** _____

Patients must notify Orthopedic Surgical Partners of the date of injury, body part, claim number, insurance company address, phone number, adjuster's name and employer information prior to their appointment. Please be informed that we may contact your employer for information regarding your claim. In addition, Orthopedic Surgical Partners has permission to provide medical documentation in order to obtain reimbursement. If Workers' Compensation is denied, and you have private health insurance, they may be billed. We will require, for this reason, your private insurance information. If neither Workers' Comp nor private insurance pays, then the patient is responsible for payment.

By signing, I have read and understand this policy and agree to comply.

Patient Signature:_____ **Date:** _____

OFFICE USE ONLY:

Received By:_____ Date: _____