

Orthopedic Surgery of Quincy, Inc.

909 Hancock Street Street, Quincy, MA. 02170

Telephone 617-773-7457 - Fax 617-773-0299

WORKER'S COMPENSATION INFORMATION

PATIENT: _____

DATE OF BIRTH: _____

EMPLOYER

NAME OF EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

EMPLOYER'S TELEPHONE: _____

WORKER'S COMPENSATION INSURANCE COMPANY

NAME: _____

ADDRESS: _____

DATE OF ACCIDENT: _____

WORKER'S COMPENSATION FILE NUMBER: _____

IF YOU HAVE AN ATTORNEY

ATTORNEY'S NAME: _____

ATTORNEY'S ADDRESS: _____

ATTORNEY'S TELEPHONE: _____

Is there a court order requiring worker's compensation payments? Yes No (Circle One)

I wish the bill for services rendered to me to be sent to the above worker's compensation insurance company. I hereby authorize release of current and all subsequent reports to the above carrier and/or employer with the bill for services rendered.

SIGNED: _____

DATE: _____

IMPORTANT: If worker's compensation denies liability for your services, this office will bill your health insurance carrier. If you have an HMO or other insurance that requires a referral, please obtain one from your primary care physician so that it will be available if needed.

Please return this fully completed form to the above address. Thank you.