WORKERS' COMPENSATION/ NO FAULT INFORMATION SHEET

WORKERS' COMPENSATION

Date of Injury:____ **Is the patient still working?** ☐ **YES** ☐ **NO**

Employer at time of Injury:____ **Job Title** ____________________________________

Phone:____

Address of Employer:____

____

Insurance Carrier:____

Address to send claims:____

____

Contact Person: ____

Phone/Fax: ____

SOCIAL SECURITY #: ____

Claim #: ____

WCB #: ____

NO FAULT (AUTOMOBILE ACCIDENT)

Date of Accident: ____

Insurance Carrier: ____

Address to send claims: ____

____

Contact Person: ____

Phone: ____

SOCIAL SECURITY #:____

Claim #:____

Workers' Compensation and No Fault patients

In the event I fail to prosecute the claim for Workers' Compensation or NO Fault for this illness or condition, or it is determined by the Workers' Compensation Board or NO Fault carrier that this illness or condition is not a result of a compensable worker's compensation case or NO fault case, I ________________________ hereby agree to pay _____________________________,
Insert location name

usual and customary fees for services rendered to the above name claimant in the above identified case.

Signature: _______________________________________ **Date:** ____