WORKERS COMPENSATION INFORMATION DATE:_________________________

PATIENT INFORMATION

NAME:________________________ BIRTHDATE:______/_____/_____ SS#: _______________________

ADDRESS:____

HOME PHONE#: (______)______________________ OCCUPATION:______________________________

EMPLOYER NAME: ____

WORK PHONE#: (______)______________________ INJURY VERIFIED BY:______________________

CONTACT PERSON:____

WORKERS COMPENSATION CARRIER: _________________________ PHONE#: _________________

CARRIER ADDRESS:____

COVERAGE VERIFIED BY: ____

CLAIM # (IF KNOWN): _________________________ ADJUSTER (IF KNOWN)_____________________

INJURY INFORMATION

DATE OF INJURY:_____/_____/_____ TIME: ____________AM/PM LOCATION:___________________

DID YOU REPORT YOUR ACCIDENT TO YOUR EMPLOYER? YES NO. IF SO, WHEN______________
WAS AN ACCIDENT REPORT FILED AT YOUR EMPLOYER'S? YES NO

NAME OF PERSON YOU REPORTED ACCIDENT TO:____

GIVE FULL DESCRIPTION OF HOW ACCIDENT HAPPENED: _________________________________
____
____
ARE YOU PRESENTLY WORKING? YES NO. IF NO, WHEN DID YOU STOP WORKING BECAUSE OF THIS INJURY? ____
WHAT IS YOUR EXPECTED DATE TO RETURN TO WORK? ____________________________________
OTHER DOCTOR(S) FOR THIS CONDITION? YES NO. NAME(S):________________________________

DIAGNOSIS: ____________________________ XRAYS?:_______________ OTHER: _________________

ANY PREVIOUS SIMILAR INJURIES? YES NO. DATES:____

DESCRIBE:____

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 TO WORKERS COMPENSATION BENEFITS ARE DENIED.

PATIENTS SIGNATURE: _________________________________ DATE: ____________________________

BUERKER CHIROPRACTIC

Dr. Sharon D. Buerker.

1660 Tower Street
Schenectady, NY 12303
Telephone: (518) 357-9892
Fax: (518) 357-9893

POLICY AND PROCEDURES

Your health and progress are our primary concerns. We are aware that worrying over mounting health care bills can affect your health. In an attempt to minimize your immediate concern and eliminate any misunderstanding we have adopted the following policies and procedures.

You have presented yourself to this office to receive care for a condition related to an on-the-job injury or automobile accident. Please be aware that New York State Laws are very specific regarding the handling of cases such as yours. It may seem as if we ask for a lot of information, but please understand that it is all necessary to the proper handling of your case.

We will initially bill the Workers Compensation or Personal Injury Carrier. It is important that you provide us with the proper name and address of the insurance carrier as well as any policy numbers available. If it is determined that this carrier is not responsible for your account, for whatever reason, you are responsible for your balance.

Some cases require the use of specific therapies and/or structural supports to achieve maximum results. These may not be covered by the insurance carrier. In such cases we must seek release from the carrier for this service. If you have received the service and the carrier will not cover it, you are responsible.

Please note that No Fault benefits do not apply to personal injury sustained by: (g) any person as a result of operating a motor vehicle while in an intoxicated condition or while his ability to operate such vehicle is impaired by the use of a drug (within the meaning of Section 1192 of the New York State Vehicle and Traffic Law).

If you engage a lawyer to assist you with your case, please inform us immediately. We will need your lawyer's name, address, and phone number.

If your working status changes; i.e. Working, not working, change of job, or job title, re-injury, etc.; we must be notified of this immediately.

Sometimes it becomes necessary for patients to cancel scheduled appointments. Kindly give this office 24 hours notice when you find it necessary to change or cancel an appointment. In Workers Compensation Cases, the Workers Compensation Board will be notified. In both Compensation and Personal Injury cases the insurance carrier will be notified. If you miss scheduled appointments or fail to follow the doctor's instructions, you may be jeopardizing both your case' and your benefits.

Thank you for your cooperation.

I certify that I have read and understood this document and that I have received a copy of it. I understand that if the insurance carrier is not liable, then I am responsible for my account.

Date:______________________________ Signature: ________________________________