Workers Compensation (WC) Information Form and Financial Agreement

Patient Name: ______________________________ Date of Birth: __________________

Social Security #: ___________________________ Date of Accident: __________________

Body Part(s) Injured: ____

WC Insurance Name: ____

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WC Claim Address: ____

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Claim ID: ____

Adjustor Name: ____________________________ Adjustor Phone #: __________________

Adjustor Email Address: ____

Employer Name: ____

Employer Phone #: ____

Patient Authorization for Billing of Services and Financial Responsibility Agreement:

I authorize the assignment of all medical payments from all insurance(s) listed above for office visits or procedures related to this accident/injury sent directly to MFM Health. In the event my WC insurance does not approve or cover services, I assume full financial responsibility. If I have Medical Health insurance, it is my responsibility to inform the billing department at MFM Health within 90 days of the date of service that is being denied along with any letters from WC stating why they are denying the claim. If both parties deny a claim, it is my responsibility to resolve this matter by contacting them. I come financially responsible for all balances due.

My signature below indicates that I understand and agree to the statement above.

Patient Signature: ______________________________________ Date: ____________

Witness Signature: ______________________________________ Date: ____________