15215 Shady Grove Rd. # 100
Rockville, MD 20850
(301) 519-0902
Fax (301) 519-0905

WORKERS COMPENSATION INFORMATION

PATIENT REGISTRATION INFORMATION

Patient Name:_____ **Date of Birth:**_____
Last First MI

Home Phone:_____ **Cell Phone:**_____ **Work Phone:** _____

EMPLOYER

Employer Name:_____ **Employer Phone #:**_____

Employer Address:_____

Contact Person:_____

EMERGENCY CONTACT

Name:_____ **Relationship to patient:**_____
Last First MI

Home Phone:_____ **Cell Phone:**_____

WORKER COMPENSATION CARRIER

Worker Compensation Carrier:_____

Carrier Address:_____

Adjuster's Name:_____ **Claim #:**_____

Adjuster's Phone #:_____

INJURY INFORMATION

Date of Injury:__/__/_____ **Time:**_____ ❑ AM ❑ PM **Body part of injury:**_____

Accident reported to employer? ❑ Yes ❑ No **Name of person you reported accident to:**_____

Give full description of how accident happened:_____

Have you lost time from work? ❑ Yes ❑ No **How much?**_____

Other doctors seen for this condition? ❑ Yes ❑ No **Doctor's Name?**_____

Were X-Rays taken? ❑ Yes ❑ No **Other tests?** ❑ Yes ❑ No **If yes to either, by whom?** _____

Please list name of test(s) and result(s)_____

Any previous Worker Compensation injuries? ❑ Yes ❑ No

Date(s) of previous injuries?_____

Describe previous Worker Compensation injuries_____

The above information is true to the best of my knowledge. I authorize Physicians Now to apply for benefits on my behalf for covered services rendered by Physicians Now, and I request my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Physicians Now or the insurance company to release any information required to process my claim. I understand that my records and medical information may be shared with my employer when that employer has requested the services provided. I consent for treatment by the patient care staff at Physicians Now and acknowledge that no guarantee can be made concerning the results of that treatment. I acknowledge that the Notice of Privacy Rights (HIPPA) has been made available to me.

Patient/Guardian Signature:_____ **Date:** _____

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www.myphysiciansnow.com

Patient Financial Responsibilities:

Thank you for choosing Physicians Now Urgent Care for your medical needs. We are committed to providing you with the highest quality of healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

· The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.

· We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.

· Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.

· Copays are due at the time of service.

· Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.

· Patients may incur, and are responsible for payment of additional charges, if applicable.

· You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to pursue the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

· By my signature below, I hereby authorize assignment of financial benefits directly to Physicians Now Urgent Care and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient name: _____

Patient or authorized person signature: _____Date:_____