perlmanclinic++

Workers Compensation Registration Form

Legal Name: Last First Middle			Date of Birth:
Date of Injury:	Time of Injury:	Effected Body Part(s):	
Pre-authorized services / procedures, if applicable:			
Name of Workers Compensation Liability Insurance:			Policy Number: Claim Number:
Claims Address: Address City State Zip			
Adjusters Name:		Phone Number: Fax Number:	
Adjusters Email:			

Patient Financial Responsibility Policy

Worker's Compensation Claims: In order to bill Work Comp claims, we must have authorization (authorizations should be in the name of Perlman Clinic, not specific providers) from the Worker's Compensation Liability insurance company, the policy number, the date and time of injury, the name of the adjuster, claims mailing address, pre authorized services/ procedures (if applicable) and claim number. All out of state Workers' Compensation visits shall be paid in full at time of visit.

Acknowledgement and Agreement:

I have entered all information to the best of my knowledge and verify the information to be accurate and true. I have read and understand the Patient Financial Responsibility Policy. I also understand that Perlman Clinic may amend such terms from time-to-time. I authorize my Auto insurance benefits to be paid directly to Perlman Clinic. I also authorize Perlman Clinic and my insurance company to release any information required to process my claims.

Printed Name of Patient _____ Relationship to Patient: Self ☐ Other_____

Signature _____ Date _____

If you are not the patient and have not already provided the information below, please complete the following:

Print Your Name: _____

Your Date of Birth: _____

Your Social Security #: _____