# ***Were You Injured On The Job?***

## EmergeOrtho, PA

## New Worker's Compensation Patient Information
## ***Check-in Staff, please fax to 919-281-1799***

**Name:** _____

**Social Security Number:** _____ **Date of Birth:** _____

**Address:** _____

**Phone:** _____ **Alternate Phone:** _____

**Employer:** _____

**Employer Address:** _____

**Contact:** _____

**Phone:** _____ **Fax:** _____

**Worker's Compensation Insurance (If known):** _____

**Date of Injury:** _____ **Injured Body Part(s)** _____

**Have you received any prior treatment? (ER, Urgent Care, Orthopedist, Neurologist, etc.)** _____

_____

**Have you had any X-Ray or MRI Films taken?** _____

**DISCLAIMER**

I understand that per NC state law (Worker's Compensation Law, 97-27), Triangle Orthopaedic Associates, P.A. reserves the right to send all medical information concerning my illness and treatment pertaining to the injury sustained on the job to the Worker's Compensation insurance carrier and/or my employer. I understand the risk involved in faxing medical information.

**DENIAL OF WORKER'S COMPENSATION**

I understand that verification of my injury DOES NOT guarantee payment of my medical bill. I understand that if my employer and/or insurance company denies a claim, a copy of the denial letter shall be sent by my employer or self-insurer/insurance company to the Industrial Commission, employer, and all known medical providers as soon as an investigation is completed. Once medical providers receive a copy of the denial letter, they may bill my private health insurance or myself as dictated by state law. If I request a hearing, the provider will discontinue billing to myself until after a hearing is held and a final decision is made. However, billing to the private health insurance may continue.

**Patient's Signature** _____ **Date:** _____