PATIENT INTAKE FORM FOR WORKERS COMPENSATION. & NO-FAULT

Today's Date: _____/______/______

Patient's Name: ____ Date of Birth: ______/_______/______

Mailing Address: ____City:________________________

State: ________________ Zip: _________________ Social Security #:___________-_______-____________

Home Phone: (_____) _______________________ Work/Cell Phone: (_____) _______________________

Please check one: ___WORKERS COMPENSATION ___NO FAULT

Insurance Co. Name: ____

Insurance Co. Address: ____

Insured's Name: ____

WORKERS COMP ONLY: Employer's Name: ______________________Employer's Phone: ______________

Claim #: _______________________________ Policy #:____

Date of Accident: _______/_____/______ Phone # of Contact Person: (_____) _______________________

NO-FAULT AUTHORIZATION

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (Authorization to Pay Benefits) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot on this form.

______ (CHECK HERE IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS)

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTHCARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVELIGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURACE LAW.

Signature: ______________________________Print Name: ______________________________ Date: _____________

Provider Signature: ____ Date: _____________

WORKERS COMPENSATION ASSIGNMENT OF BENEFITS

I understand that if my Workers Compensation insurance denies payment for services that have been rendered to me I will be financially liable for those services. In the event that my Workers Compensation insurance denies paying my claim, I authorize River Radiology, PLLC to bill my major medical carrier for those services. I agree that if my major medical carrier refuses to pay for those services, I will continue to be financially liable for the unpaid service.

Patient's Signature: ____ Date: ____________

Witness: ____ Date: ____________

MAJOR MEDICAL INSURANCE

Insurance Company Name: ____

Insurance Company Address: ____

Insured's Name: (Circle One: SELF, SPOUSE, PARENT) ____

Insured's Date of Birth: ______/______/______ Member ID#:___________________Group#:____________________

Revised 7/01/09