

DeFalco Family Chiropractic

32 Auburn Street • Auburn, Massachusetts 01501 Phone (508) 832-2396 • Fax (888) 648-5635 • www.DeFalcoChiropractic.com

FINANCIAL POLICY CONCERNING WORKERS COMPENSATION

As a new patient, you may not be aware of our policy regarding payment for services. We have found that it is best to outline these policies to eliminate any misunderstanding.

If you have been involved in an on-the-job injury, you are entitled to receive medical treatment. The injured party, in most instances (check your state law) is allowed freedom of choice in selection of a doctor.

To activate you claim you must do the following:

- 1. Report your injury and complete and accident report and have it on record with your employer.
- 2. Furnish this office with **ALL** pertinent information that relates to the accident. Specifically:

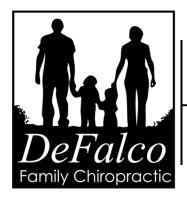
Provide our office with the employer name, address and phone Provide our office with the employer's worker's compensation insurance company name, address, phone number and the claims adjustor's name.

Please understand that you are always solely responsible for your bill. Failure to comply with the above will result you paying your bill on a per visit basis until we receive the requested information.

We need pre-certification for all work-related injuries, and we will call the proper parties in order to receive pre-certification for your care and treatment. Pre- certification does not guarantee payment by the insurance carrier. If the claim has been denied, you will responsible for the services rendered to you by this office. We will bill services rendered to the insurance company and will be paid to us directly. Charges for missed appointments will not be billed to the insurance carrier and are your responsibility at your next scheduled appointment. The charge for a missed appointment is \$25.00.

If you seek legal counsel, you must notify our office immediately. You and your lawyer will be asked to sign a doctor's lien at that time.

Patient signature (parent if minor)	Date
(patient initials)	(staff initials)



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WORKER COMPENSATION INFORMATION

Date	_		
	Patient Information	on	
Name	DOB	SS#	
Address			
Telephone #	Occupation		
	Employer		
Employer Name			
Employer Address			
Employer Telephone			
Contact Person			
Injury Verified By			
	Worker Compensation	Carrier	
Worker Compensation Carrier			
Carrier Address			
Carrier Phone #			
Claim #			
	Injury Informatio	n	
Date of Injury	Time		()AM()PM
Place of Injury			
Accident reported to employer? () YE			
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 doctor's seen for this condition:	
Doctor's Name Diagnosis	
Were x-rays taken? () YES () NO Other tests? () YES () NO	
If yes, by whom? Please list test(s) and result(s)	
Any previous Worker's Compensations Injuries? () YES () NO	
Date of previous injuries	
Describe previous Worker's Compensation Injuries	
Authorization	
I clearly understand and agree that all services rendered to me are charged directly to me and that I am personal	lly
responsible for payment in the event that my claim for Worker's Compensation benefit is denied.	
Patient's Signature Date	



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AGREEMENT TO PAY COST IN THE EVENT OF WORKER'S COMPENSATION DENIAL

Claimant Name:		SS#:			
Address: Street	Ci	ty	State	Zip	
Employer:					_
Address: Street		ty	State		_
Street	Ci	ıy	State	ΖΙΡ	
nsurance Carrier:					_
Date of Injury:					
f it is determined by tl compensable worker's	he workers compensation compensation	board that th	e above named	claim is not a re	esult of a
,			hereby agree	to pay Dr. Fran	cis DeFalco the
usual and customary fo	ee for services rendered.				
Date	Signature				
f signed by other than	claimant, complete belov	w.			
Name and Address		Relatio	nship		<u> </u>