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

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 #____________________________________ Adjustor ____

Injury Information

Date of Injury __________________________________Time ___________________________ ( ) AM ( ) PM

Place 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 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 personally 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 City State Zip

Employer: ____

Address: ____
Street City State Zip

Insurance Carrier: ____

Date of Injury: ____

If it is determined by the workers compensation board that the above named claim is not a result of a compensable worker's compensation case.

I,____ hereby agree to pay Dr. Francis DeFalco the usual and customary fee for services rendered.

Date______________________Signature____

If signed by other than claimant, complete below.

____ _____________________________________
Name and Address Relationship