AfterOurs Urgent Care Workers' Comp Patient Information

PATIENT FIRST NAME: _____ LAST NAME: _____DOB:_____

ADDRESS: _____ CITY/STATE/ZIP: _____

HOME #: _____ CELL (optional):_____

MARITAL STATUS: _____ SEX: _____ SS#: _____

I would like to receive my billing statement electronically. Send my E-Statement to:_____

Please circle:

Please email occasional offers and health updates to the email above. Do not email me offers, and important health updates.

EMERGENCY CONTACT: _____ PHONE: _____ RELATION: _____

WORKERS' COMP INSURANCE COMPANY: _____

INSURANCE ADDRESS: _____ CITY/STATE/ZIP: _____

ADJUSTER NAME_____ ADJUSTER PHONE # _____

CLAIM #: _____ DATE OF ACCIDENT/INJURY _____

EMPLOYER: _____ OCCUPATION: _____

SUPERVISOR: _____ EMPLOYER PHONE: _____

FAX RECORDS TO SECURE FAX #: _____

I give AfterOurs permission to speak with and/or leave messages regarding my medical care and/or billing with the following. I understand this consent will remain valid until revoked in writing.

CONTACT NAME: _____ TELEPHONE: _____

DESCRIPTION OF INCIDENT:_____

_____

_____

CONSENT TO TREAT: I voluntary consent to medical treatment and procedures that may be performed on me during this visit. This includes, but is not limited to, medical, therapy, or surgical care, x-rays, tests, medications, laboratory test, or other services, which may be ordered by the physician participating in my care.

ASSIGNMENT OF INSURANCE BENEFITS, PAYMENTS, AND RELEASE OF MEDICAL RECORDS: I hereby authorize payment of medical benefits to AfterOurs™ Incorporated. I further authorize the release of any medical/surgical information necessary for determining the extent of third-party coverage and for processing an insurance claim on my behalf. I permit a copy of this authorization to be valid as the original. I understand that I am ultimately responsible for and agree to pay all charges and expenses of the clinic for services, supplies, and food furnished to me which are not paid through benefits for prepaid healthcare, insurance plans, or medical assistance. If for any reason my account is forwarded to a collection agency or attorney for non-payment, I agree to pay all collection cost, court cost, attorney's fees and other reasonable cost incurred if I am found liable for amounts due to AfterOurs™ Incorporated.

X_____ Date: _____ Time:_____

Patient Signature

X_____

Print Name