



## Workers' Compensation Questionnaire & Agreement

Patient Name: \_\_\_\_\_ SS #: \_\_\_\_\_ DOB: \_\_\_\_\_

What part(s) of your body did you injure at work? \_\_\_\_\_

What **DATE** did your injury occur? (BE AS SPECIFIC as possible) \_\_\_\_\_

**WHERE** did your injury occur? (BE AS SPECIFIC as possible) \_\_\_\_\_

**HOW** did your injury occur? \_\_\_\_\_

Did anyone witness your injury?  Yes  No If **YES**, who? \_\_\_\_\_

What **DATE** did you report the incident to your employer? \_\_\_\_\_

**WHAT** is the name & phone number of your company? \_\_\_\_\_

Name of your current supervisor? \_\_\_\_\_

What **DATE** were you first evaluated and/or treated for this medical condition? \_\_\_\_\_

Have you stopped working as a result of this injury?  Yes  No

If **YES**, Date you stopped working: \_\_\_\_\_ Are you still off work due to this injury?  Yes  No

Have you ever had a similar medical problem or injury?  Yes  No If **YES**, when? \_\_\_\_\_

If **YES**, please describe the similar medical problem or injury: \_\_\_\_\_

Have you received previous treatment for your injury?  Yes  No

If **YES**, please list ANY and ALL sources and dates of treatment below:

Who treated you?	Date?


**Please provide us with the following information:**  
 (You can obtain this information from your employer)

<b>Workers' Compensation Insurer:</b>	
<b>Address:</b>	
<b>Telephone:</b>	
<b>Contact Name:</b>	
<b>Claim No:</b>	

Have you retained an attorney?  Yes  No

If YES, please provide us with the following information

<b>Attorney's Name:</b>	
<b>Address:</b>	
<b>Telephone:</b>	

I testify that my injuries are the direct result of the above mentioned incident. I fully understand that I am responsible for any charges incurred due to the treatment of my medical condition. In addition, I also understand that it is my responsibility to provide *Aram & Lawhorn, PC* with all necessary information from my employer or other sources in order to file a complete claim. I understand that if the proper and complete information is provided by me, *Aram & Lawhorn, PC* will make a diligent attempt to retrieve payment for services provided to me from the workers' compensation insurance company **in cases that have been deemed to be covered** by workers' compensation insurance. If my case is not deemed to be covered by workers' compensation insurance, I understand I am expected to follow the guidelines set forth in the Financial Policy form I signed.

By signing this document all terms and conditions provided in this document shall be valid and binding upon me for any present or future services provided to me by *Aram & Lawhorn, PC* for this condition. I also hereby acknowledge receipt of a copy of this document. I understand I have the right to refuse to sign this agreement and pay for all care at the time of service.

If the undersigned is not the Patient, the undersigned represents and warrants that they have full legal authority to sign this document on behalf of the Patient and understands that they are also responsible for all charges incurred due to services, present and future, provided for the Patient's medical condition.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_