Employer Information

Name of Employer:_____

Address and phone number of Employer: _____

Have you reported the accident to your employer? YES NO If "no", please contact your employer and submit an incident report as soon as possible.

Name of Workers' Compensation Carrier: _____ Phone number: _____

Address we are to submit claims to: _____

Legal Representation

Do you have an attorney? YES NO

If "yes", Name and address: _____

_____

_____

Please notify us if your attorney information changes.

Assignment of Benefits and Authorization to Release Information

I, the undersigned, certify that I (or my dependent) have chiropractic coverage through the above mentioned Workers' Compensation Company and assign directly to Princeton Family Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.
I hereby authorize Princeton Family Chiropractic to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature Date