

Crystal Plastic Surgeons, Inc. | Worker's Compensation Patients

Date: _____ Doctor of Record: _____

Patient Information

Patient Name		Patient Social Security Number		
Address	City	State	Zip Code	
	M F		S M W D	
Birthdate	Age	Sex	Marital Status	
Home Phone Number		Work Phone Number		

Employer & Injury Information

Employer	Employer Address	City	State	Zip Code
MCO/Self-Insured Contact Person		Phone Number		
Claim Number	Date of Injury	Body Part		

Primary Insurance Carrier

Insurance Carrier	Group Number	Policy Number		
Policy Holder Name	Employer	Relationship to Patient	Policy Holder's SS Number	
Policy Holder Birthdate	Insured Address (if different from above)	Phone Number		

Financial Policy Procedure

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which you are required to read and sign prior to any treatment. We do not render services on the assumption that your charges will be paid by your employer or by the Bureau of Worker's Compensation. Patients who are injured on the job are responsible for payment of services rendered. We will submit the charges for you, but if your claim is denied or goes into litigations, it will be your responsibility to pay for the services.

MAY WE LEAVE INFORMATION WITH PERSON AT RESIDENCE OR ON VOICE MAIL? Yes No

I have read the Financial Policy and I understand and agree to this Financial Policy.

Date: _____ Signature: _____