First State Physicians

Physical Medicine & Rehabilitation Center

Kevin J. McDermott, D.C.

Insurance information for Workers' Compensation Claim

Insurance Company: _____ Date of Accident: _____

Claim # _____

Adjuster's Name/Phone #: _____

Do you have an attorney handling this case? (circle) YES NO If yes, who? (name/address/phone) _____

_____

_____

If no, would you like us to suggest an attorney for you? _____

Assignment of Payment

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to First State Physicians any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay First State Physicians the difference, if any between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned agree to pay First State Physicians the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Patient Signature: _____ Date: _____

Printed Name: _____

Who referred you to our office today? _____