Orthopaedic Sports Specialists
Workers' Compensation Registration Form

PATIENT NAME:_____

EMPLOYER NAME:_____

EMPLOYER CONTACT:_____

WORKERS' COMP. CARRIER:_____

COMP CARRIER ADDRESS:_____

_____

CLAIM FILE #_____

CLAIM ADJUSTERS NAME:_____

ADJUSTER PHONE#(_____)_____FAX #_(_____)_____

DATE OF INJURY:_____

INJURED BODY PART:_____LEFT OR RIGHT

NURSE CASE MANAGER AND PHONE #_(_____)_____
(If known)

By signing this form, you agree to fulfill your obligations as a patient under Connecticut Workers' Compensation law. Patients are required to promptly report the work related injury to their employer and accept initial treatment from an employer designated physician. It is also your responsibility to obtain approval for treatment with a specialist and obtain all pertinent billing information listed above prior to your appointment.

In the event that the workers' compensation carrier or your employer dispute your claim or the nature of your injury, you would be liable for the expenses of all medical care and supplies that have been provided to you. Your personal health insurance may offer coverage for you when the claim has not been accepted or approved for workers' compensation coverage. If you do not have medical coverage, you would be solely responsible for payment regardless of any pending litigation.

_____ _____
PATIENT SIGNATURE DATE