

4. Complete this section only if this is Workers Compensation (Job Related Injury)

Employer Name _____ Date of Injury _____
Employer Address _____
(Street) (City) (State) (Zip)
Contact Person to Verify W/C _____ Phone # _____
Carrier Name _____
Carrier Address _____
(Street) (City) (State) (Zip)
Claim # _____ Carrier Phone # _____

Does your job require the following (please circle all that apply)?

- | | | |
|------------------------------------|-----------------------------------|---------------------------------------|
| 1. Very Little Lifting (0-10 lbs.) | 5. Frequent Bending & Lifting | 9. Continuous Standing |
| 2. Light Lifting (11-20 lbs.) | 6. Frequent Squatting or Kneeling | 10. Sitting |
| 3. Medium Lifting (21-50 lbs.) | 7. Climbing | 11. Repetitive motion upper extremity |
| 4. Heavy Lifting (over 50 lbs.) | 8. Extended Walking | 12. Repetitive motion lower extremity |

**If your problem/injury is the result of an auto accident or workers compensation, is an attorney representing you?

No Yes If yes, which attorney? _____

In Case of an emergency, name the nearest local relative or friend (Not living with you):

Name _____ Phone # _____

I hereby certify that the information provided above is complete and correct. I authorize Cape Fear Orthopaedic Clinic, PA to submit claims and assign benefits, on my behalf, to my insurance company. I agree to be financially responsible for services and materials not paid by my insurance benefit plan, unless the treating physician has a contractual agreement with my insurance plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize the release of any health information related to this claim.

Signed (Patient/Parent/Guardian)

Date

FOR MEDICARE PATIENT'S ONLY

Do you have other health insurance besides Medicare? NO Yes

If yes, Are you currently employed?

NO YES Does your employer have more than 100 employees? Y N

If yes, Is your spouse currently employed?

NO YES Does your spouse's employer have more than 100 employees? Y N

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Cape Fear Orthopaedic Clinic, P.A., for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS), and its agents, any information needed to determine these benefits or the benefits payable for related services.

Signature _____ Date _____