F Kelly Cunningham MD, PA

12401 Hymeadow Drive Suite 1B Austin, TX 78750
Phone: 512-410-0767 Fax: 512-649-7402

DISCLOSURE

To provide efficient quality service to the patient, we require that you carefully review and sign the following agreement. (Pursuant to TWCC Rule 120.1 FIGURES 1 & 120.2)

If you are seeking care at our office for an injury/condition due to work, please note that we are required by the Texas Workers' Compensation Commission laws to handle your claim with your employer's Workers' Compensation Insurance Carrier. After you have reviewed the provided information, please check the most applicable statement.

□ I certify that my injury/condition **IS w**ork related.

Should your injury become fully adjudicated not to be compensable as defined by the Division of Worker's Compensation or the insurance carrier is relieved under 408.024 of the Texas Worker's Compensation Act, or your claim is denied, you will assume all financial responsibility for the billing of your injury/condition; at which time, you may provide your private health insurance information.

□ I certify that my injury/condition **IS NOT** work related.

AGREEMENT

As a patient of Kelly Cunningham M.D., with a work related injury/condition, it is your responsibility to inform the facility immediately of the following.

- You must provide us with your employer's information:
  - Name of the Company
  - Name of the contact person
  - Phone Number
- You must provide us with your employer's Workers' Compensation Insurance Carrier Information:
  - Name of the carrier
  - Name of contact person
  - Claim #
  - Phone number
- You must inform this facility if you have had any of the following:
  - Designated Doctor Evaluation
  - Required Medical Evaluation
  - Impairment Ratings
- You must immediately notify us if your claim is disputed, denied, or if you receive a Notice of Refusal to Pay Benefits, more commonly referred to as a DWC 021 and/or PLN-11.

Failure to disclose any of the above information in a timely manner will cause you (the patient) to become financially responsible for all services rendered. Should you have questions regarding the disclosure, please ask to speak to a Worker's Compensation Representative.

ACKNOWLEDGEMENT

Signature: ______________________________________ Date: __________________________

Patient Name: __________________________________