976 Mountain City Hwy, Elko Nevada 89801
Phone: 775-777-7587 Fax: 775-738-9584

ACKNOWLEDGEMENT OF RESPONSIBILITY FOR CHARGES RELATED TO *WORK RELATED INJURY/ILLNESS*

Employer: _____

Address: _____

Phone #: _____ Contact Name: _____

Insurance Carrier Name: _____

Address: _____

Phone #: _____ Claim #: _____

By signing below, I, _____, acknowledge that I have been informed that I or my company must provide the workers compensation claim number for my case by the end of the third business day of being seen at A+ Total Care. I or my company must also provide the name of the insurance carrier, address and phone number. I understand that failure to provide the requested information within the above mentioned time frame will make me responsible for the full amount of the charges. I also understand that my health insurance company cannot be billed for work related injury/illness if the above mentioned information is not received.

In the event that the necessary information is obtained after I have paid the charges, I acknowledge that A+ Total Care will bill the worker's compensation carrier and will reimburse me after the claim has been paid by the carrier.

_____ _____
Patient/Guardian Signature Witness

_____ _____
Print Name of Patient Patient's Date of Birth

_____ _____
Today's Date Date of Accident