INDIANA SPINE CENTER
WORKMAN'S COMP INFORMATION

Date_____

Patient's Name_____
Last First MI

The following information is necessary in order for Indiana Spine Center to file your charges with Workman's Compensation.

Employer's Name_____

Employer's Address_____

Employer's Phone_____

Insurance ID_____

Date of Injury_____

Please give a brief description of how, when, and where the injury occurred, and <u>what body part was injured</u>. .

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WITHOUT THIS INFORMATION, WE WILL NOT BE ABLE TO FILE YOUR CHARGES AND IT WILL BE YOUR RESPONSIBILITY TO SUBMIT THESE CHARGES TO YOUR EMPLOYER.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize payment directly to the Indiana Spine Center and the release of any information necessary to my employer's workman's comp insurance company.

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Signature of Patient Date