

## INJURY INFORMATION

If your visit today is due to an injury sustained at work please complete all the following questions. We require a written or verbal approval from your workmans compensation carrier before you are send by the doctor.

OR

If you sustained your injury in an accident and another insurance company other than your own medical insurance carrier is covering your medical expenses for this injury please complete the following questions.

Date of injury \_\_\_\_\_

Place injury occurred \_\_\_\_\_

Workmans Comp or Insurance Co.

Covering medical expenses \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Contact Person \_\_\_\_\_

I understand that Cedar Valley Podiatry may request that payment on my account be made by me prior to my workers compensation or other responsible insurance companies paying on my claim(s), or my medical insurance carrier may be billed. I also understand a refund will be paid to0 me if or when the workers comp or other insurance companies involved makes payment on claims I have paid on.

Signature \_\_\_\_\_ Date \_\_\_\_\_