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Worker's Compensation Information

About the patient

Full Name: ____

Full Address: ____

Contact phone number: ____________________ or ____________________

About the Employer

Company/Business Name: ____

Company/Business address: ____

OH&S/Employer contact name: ____

OH&S/Employer contact number: ____

About the Insurer

Name of Insurance Company: ____

Address of Insurance Company: ____

Name & phone number of case manager: ____

Direct phone number of case manager: ____

Has liability been accepted by Insurer? Yes □ No □ Don't know □

Claim number: ____

All worker's compensation consultation fees are to be paid at the time of the consultation. Until such time as a letter of liability and claim number is issued, the patient is solely responsible for all worker's compensation fees.

Worker's compensation fees do not incur a Medicare rebate.

I, (please print name) ______________________________ understand all consultations regarding this current work cover claim will be solely my financial responsibility, until such time as a letter of liability and claim number is issued. I understand I am not able to claim a rebate through Medicare for these consultations.

Signed: ______________________________ Date: ____________________