SPECTOR CHIROPRACTIC

DR. NORMAN F. SPECTOR

WORKER'S COMPENSATION DIRECT PAYMENT AUTHORIZATION

Date of Accident:

Has this accident been reported to your employer? [ ] YES, [ ] NO

Worker's Compensation Insurance Information:

WC Insurance Co. Name:

WC Claims Number:

WC Claims Address:

Contact Name: _____ Phone:

Employer's Information:

Employer's Name (at time of accident): _____ Employer's Address:

_____

City: _____ State: _____ Zip: Supervisor's Name: _____

Phone: ( ) _____

Attorney's Information (if Applicable):

Attorney's Name: _____

Attorney's Address:

I (the undersigned) request direct payment of authorized medical benefits be made to Spector Chiropractic for any service furnished to me by these medical providers. I authorize any holder of medical information about me to release this information to my insurance carrier (or intermediaries) to the Health Care Financing Administration and its agents, to my attorney or another medical providers office. Also I permit a copy of this authorization to be in place of the original copy. This assignment will remain in effect until I revoke, in writing, this authorization. I understand that because these services were performed for my legal dependent, or me I am financially responsible for all charges whether or not paid by the insurance carrier.

Print Patient's Name:

SIGNATURE: _____ DATE: