2015

Applied Pain Institute LLC

1015 S. Mercer Avenue
Bloomington, IL 61701

Worker's Compensation Payment Agreement

If our services are related to a Worker's Compensation claim please review the following information.

You are legally responsible to this office for payment for services provided to you.

- If your claim is turned over to an attorney for settlement and no court date is set within six months of your first visit to our office the guarantor/patient is responsible for payment.
- If your claim is denied the guarantor/patient is responsible for payment.

If you have questions about your worker's compensation claim as it relates to payment, please speak with our billing staff before signing this form.

Date of Injury: ____________________ SSN: ______________________

Employer at time of injury: ____ (phone) ________________

Insurance Company: ____(phone)________________

Address: ____

City: ___________________________________ State/Zip: ______________________

Adjustor's Name: ____(phone)____________________

Claim Number: ____________________________________

Attorney's Name: ____ (phone)____________________

Attorney's Law Firm Name: ____

Attorney's Address: ___________________________________ State/Zip: ____________________

Your signature below indicates that you have read and understand this policy. Thank you for your cooperation.

____ ___________________________
Print name of patient/authorized representative Date

____ ___________________________
Signature of patient/authorized representative Date

If Personal Representative's signature appears above, please indicate relationship to patient and provide a copy of legal authority to act on patient's behalf.

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Relationship (POAH, Guardian, Custodian, etc.)