Albemarle Family
FOOT & ANKLE

1410 Incarnation Drive Suite 202
Charlottesville, VA 22901
434.979.0728

Workers Compensation Injury Information

Patient Name____ Date of Birth______________________

Date of Injury:

Employer____ Work Phone_______________________

Work Address____

Position at work____

Describe Accident:

TREATMENT FOR ALL WORK-RELATED INJURIES MUST BE AUTHORZIED BY THE EMPLOYER. WHO SHOULD WE CONTACT?

Name____ Phone____________________________

Have you been treated by any other doctor for this injury? ☐ Yes ☐ No

If yes, who?_______________________________________ When?___________________________

Have you retained an attorney? ☐ Yes ☐ No

Attorney Name_____________________________________ Phone___________________________

**************************IMPORTANT – PLEASE READ CAREFULLY****************************

If you are here for treatment due to an accident at work, be sure you have file a report with your employer. If we are unable to verity this injury as a workers' compensation injury, you will be responsible for payment of any and all charges for your care.

Patient Signature____ Date__________________________

OFFICE USE ONLY

Staff Initials__________ Workers Comp Verified? ☐ Yes ☐ No Date________________________

Contact Name____ Phone______________________

Claim Address:

☐ Itemized Bill ☐ CMS-1500 Form