

4. Complete this section only if this is Workers Compensation (Job Related Injury)

Employer Name _____ Date of Injury _____
Employer Address _____
(Street) (City) (State) (Zip)
Contact Person to Verify W/C _____ Phone # _____
Carrier Name _____
Carrier Address _____
(Street) (City) (State) (Zip)
Claim # _____ Carrier Phone # _____

Does your job require the following (please circle all that apply)?

- | | | |
|------------------------------------|-----------------------------------|---------------------------------------|
| 1. Very Little Lifting (0-10 lbs.) | 5. Frequent Bending & Lifting | 9. Continuous Standing |
| 2. Light Lifting (11-20 lbs.) | 6. Frequent Squatting or Kneeling | 10. Sitting |
| 3. Medium Lifting (21-50 lbs.) | 7. Climbing | 11. Repetitive motion upper extremity |
| 4. Heavy Lifting (over 50 lbs.) | 8. Extended Walking | 12. Repetitive motion lower extremity |

Do you currently have an attorney representing you for your injury/problem? No Yes – Attorney _____

FOR MEDICARE PATIENT'S ONLY

Do you have other health insurance besides Medicare? NO Yes

If yes, are you currently employed? NO Yes – Does your employer have more than 100 employees? No Yes

If yes, is your spouse currently employed? NO Yes – Does your spouse's employer have more than 100 employees? No Yes

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Cape Fear Orthopaedic Clinic, P.A., for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS), and its agents, any information needed to determine these benefits or the benefits payable for related services.

X _____
Signature Date

I hereby certify that the information provided above is complete and correct. I authorize Cape Fear Orthopaedic Clinic, PA to submit claims and assign benefits, on my behalf, to my insurance company. I agree to be financially responsible for services and materials not paid by my insurance benefit plan, unless the treating physician has a contractual agreement with my insurance plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize the release of any health information related to this claim.

X _____
Signature of Patient or Legal Guardian Date

As part of our efforts to comply with HIPAA Privacy Regulations, we ask that you please provide the name of family members or other persons, if any, to whom we may release information regarding your general medical condition, financial account, or who have permission to pick up information you have requested

Name: _____ Relationship: _____
Name: _____ Relationship: _____

I have been given a copy of the Cape Fear Orthopaedic Notice of Privacy Practice, version effective 2/1/2010. I consent to the uses and disclosures of my health information as outlined in the Notice.

X _____
Signature of Patient or Representative Date

Representative is the: () Parent or legal guardian of the patient, who is a minor
() Guardian of the patient, who has been adjudicated incompetent.
() Representative acting under a Durable Power of Attorney for Health Care or Advance Directive for the patient, and has presented a copy of this document to Cape Fear Orthopaedic personnel.