



Community Based Imaging Excellence for Over 30 Years

Accredited by the American College of Radiology

**WORKER'S COMPENSATION INFORMATION**

Name (last) \_\_\_\_\_ (first) \_\_\_\_\_ (mi) \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Sex (M/F) \_\_\_\_\_ Age \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone # \_\_\_\_\_  
 Mailing Address (if different) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Alternate Phone # \_\_\_\_\_  
 Employer's Name \_\_\_\_\_  
 Address \_\_\_\_\_ P.O. Box \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Ph # \_\_\_\_\_ Ext \_\_\_\_\_  
 Supervisor's Name \_\_\_\_\_ Phone # \_\_\_\_\_ Ext \_\_\_\_\_  
 Date and Time of Injury \_\_\_\_\_  
 How Did Accident/Injury Occur? \_\_\_\_\_  
 Who Did You Report Your Injury To? \_\_\_\_\_  
 Referring Physician \_\_\_\_\_ Copies of Report to: \_\_\_\_\_

**AGREEMENT TO PAY MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE OR IF COMPENSATION CLAIM IS DISALLOWED**

|                                       |                |   |
|---------------------------------------|----------------|---|
| Co. Case #                            | Carrier Case # | Nature of Illness or Injury             |
| Worker Compensation Insurance Carrier |                | Worker's Compensation Insurance Phone # |

IN THE EVENT I FAIL TO PROSECUTE THE CLAIM FOR WORKER'S COMPENSATION FOR THE ILLNESS OR CONDITION, OR IT IS DETERMINED BY THE WORKMAN'S COMPENSATION BOARD THAT THE ILLNESS OR CONDITION IS NOT THE RESULT OF A COMPENSABLE WORKER'S COMPENSATION CASE, I, \_\_\_\_\_ hereby agree to pay Housatonic Valley Radiological Associates, PC, or its affiliates usual and customary fees for services rendered to the above named claimant in the above identified case. I understand I will be responsible for any and all charges I will have incurred in seeking services at this office.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If signed by other than claimant, Print Below:

Name \_\_\_\_\_ Relationship of Signer \_\_\_\_\_  
 Address \_\_\_\_\_ P.O. Box \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_