Workers Compensation

DUPAGE CHIROPRACTIC CENTRE, LTD.

DR. SALLY A. PEPPING
DR. DON MERTES

Dear patient,

Thank you for choosing DuPage Chiropractic Centre to help you with the injuries that you recently sustained while at work. Because situations like this are not only frightening, but can also be confusing, we want you to know that our office specializes in taking care of all aspects of your care. Please do not get overwhelmed with any insurance questions, leave that up to our staff. Your job is simply to follow our doctor's recommended care program so you may regain your health.

Below you will find all the information we will need from your accident. Once we receive all of this information, the case will be handled exclusively by our billing department.

1. Completion of all DuPage Chiropractic paperwork.
2. Completion of a *"State of Illinois report of first injury"*. This is filled out when you report this injury to your supervisor. Please fill this out **immediately** and bring a copy of it to our office or have it faxed to us at 630-858-9793.

If you have any questions or need help in obtaining this information, please give our office a call Monday, Tuesday, Wednesday, or Friday from 9:30-6:30 and we will be happy to help you. Or you can call Lynn in our billing department directly. She can be reached at 630-858-9780 x3.

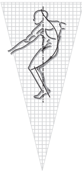
We look forward to helping you regain the health that you have recently lost.

Thank you,

Dr. Sally Pepping
Dr. Don Mertes
And Staff

PAIN MANAGEMENT • MASSAGE • PHYSICAL THERAPY

45 S. Park, Suite 155 • Glen Ellyn, IL 60137 • (630) 858-9780 • Fax (630) 858-9793
www.dupagechiropractic.com



DuPage Chiropractic Centre, Ltd

Worker Compensation Information

Date: ______________________________

PATIENT INFORMATION

Name: ______________________________
Address: ______________________________ City: ______________________________
State: __________________ Soc. #: ______________ Children? ______________________________
Telephone: ______________________ Occupation: ______________________________
Sex ❒ M ❒ F Who may we thank for referring you? ______________________________
In case of emergency who should be notified? ______________________________
List medications currently taking: ______________________________
____
____

EMPLOYEE

Employer Name: ______________________________
Employer Address: ______________________________
City: ______________________________ State: __________ Zip: ______________________
Employer Telephone: ______________________ Contact Person: ______________________________

WORKER COMPENSATION CARRIER

Worker Compensation Carrier: ______________________________
Carrier Address: ______________________________
City: ______________________________ Sate: __________ Zip: ______________________
Carrier Phone Number: ______________________________
Adjuster's Name: ______________________ Claim Number: ______________________________

INJURY INFORMATION

Date of Injury: ______________________ Time: __________ ❒ AM ❒ PM
Place of Injury: ______________________________
Accident reported to employer? ❒ Yes ❒ No Name of person you reported accident: ______________________
Give full description of how accident happened: ______________________________
____
____
____
Have you lost time from work? ❒ Yes ❒ No How much? ______________________________
Other doctors seen for this condition: ______________________________
Doctor's Name: ______________________ Any medications prescribed? ______________________
Were X-Rays taken? ❒ Yes ❒ No Other Tests? ❒ Yes ❒ No
If yes, by whom? Please list test(s) and result(s): ______________________________
____
____
Any previous Worker Compensation injuries? ❒ Yes ❒ No Dates of previous injuries: ______________________
Describe previous Worker Compensation injuries: ______________________________

AUTHORIZATION

I clearly understand that DuPage Chiropractic Centre is filling my workers compensation claim as a courtesy to me. That if my claims are denied I am responsible for all payment. I agree to be an active participant in my case and keep in contact with my adjuster to make sure my claims are paid and to keep DuPage Chiropractic center aware of any changes or attorney's assigned to my case. And agree that if my claims are not paid 60 days after my care is completed I will make a good faith effort to pay DuPage Chiropractic Centre.

Patient's Signature: ______________________________ Date: ______________________________