NEUROLOGY GROUP of BERGEN COUNTY

www.neurobergen.com

Adult Neurology
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Biofeedback
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Managing Partner
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Associate Managing Partner
Kenneth A. Citak, MD

Chief Operating Officer
David T. Contento, FACMPE

WORKMAN'S COMP

Patient Name: _____ Date: ___ / ___ / ___

If the reason you are coming to our office is due to a work-related accident, please answer the following:

Date of Accident: ___ / ___ / ___

Describe the circumstances:

_____

_____

_____

_____

Were you hospitalized?: Yes ☐ / No ☐

What hospital were you admitted to?: _____

What doctors were in attendance?: _____

Were any X-Rays taken?: Yes ☐ / No ☐ Type of X-Ray?: _____

What type of treatment did you receive?: _____

If you lost time due to your accident, please provide the dates: ___ / ___ / ___ -until- ___ / ___ / ___

Please list the name and addresses of your insurance carrier responsible for medical care related to the accident:

_____

_____

_____

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE PAYMENT OF BENEFITS TO NEUROLOGY OF BERGEN COUNTY FOR MEDICAL CARE RENDERED TO ME AS A RESULT OF THE ABOVE-DESCRIBED ACCIDENT.

SIGNATURE: _____ DATE: ___ / ___ / ___

I HEREBY AUTHORIZE NEUROLOGY GROUP OF BERGEN COUNTY TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO THE INSURANCE COMPANY (IES) FOR THE PAYMENT OF MY BILLS.

SIGNATURE: _____ DATE: ___ / ___ / ___