

# WORKER'S COMPENSATION REGISTRATION

Carlsbad Imaging Center  
3144 El Camino Real Suite 100  
Carlsbad, CA 92008  
Fax # (760) 720-4833  
(760) 730-3536

1. Date: \_\_\_\_\_
2. Patient's Name: \_\_\_\_\_
3. Address: \_\_\_\_\_ Home Phone: (    ) \_\_\_\_\_
4. City: \_\_\_\_\_ Zip Code: \_\_\_\_\_
5. Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
6. Employer's Name at time of Injury: \_\_\_\_\_
7. Employer's Address: \_\_\_\_\_
8. City: \_\_\_\_\_ Zip Code: \_\_\_\_\_
9. Phone Number: \_\_\_\_\_ Date of Injury: \_\_\_\_\_
10. Referring Doctor's Name: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_
11. Attorney's Name: \_\_\_\_\_
12. Attorney's Address: \_\_\_\_\_
13. City: \_\_\_\_\_ Zip Code: \_\_\_\_\_
14. Attorney's Phone Number (    ) \_\_\_\_\_ Fax Number (    ) \_\_\_\_\_
15. Work Compensation Carrier: \_\_\_\_\_
16. WC Address: \_\_\_\_\_
17. City: \_\_\_\_\_ Zip Code: \_\_\_\_\_
18. WC Phone Number: (    ) \_\_\_\_\_ WCAB# \_\_\_\_\_
19. Authorized by: \_\_\_\_\_
20. Adjuster's Name: \_\_\_\_\_ Claim Number: \_\_\_\_\_

**AUTHORIZATION OF RELEASE OF MEDICAL RECORDS AND FILMS**

I, \_\_\_\_\_, hereby authorize, the above named facility, to release the medical records, diagnostic report and /or film of:

Patient's Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Medical Record# \_\_\_\_\_  
Specific exam/exams: \_\_\_\_\_ Date of service: \_\_\_\_\_  
To: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

I understand that this authorization shall become effective immediately and shall remain in effect until I revoke it, in writing. I also agree to pay any fee associated with copying of second set of films.  
Applicable Fees: \$15.00 per film

Print Name: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION**

† **ASSIGNMENT OF BENEFITS:** I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due me under my insurance plan. I also hereby authorize this provider to use and disclose any of my personal medical information for treatment/diagnosis and payment (including to my insurance company). I agree to pay the balance of charges not paid under my plan. I am aware that if my account is not paid in full within 90 days from the date of the service, a 30% additional fee will be added to the balance and it will be sent directly to a collection agency and reported to a national credit bureau. The returned checks will also be charged a \$25.00 fee. Should the account be referred to an attorney for collection, the undersigned shall pay attorney's fees and other collection expenses. **IF I AM UNINSURED, I am fully responsible for all charges.**

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

† **CONSENT FOR MEDICAL TREATMENT/DIAGNOSIS:** I authorize the imaging Center to furnish the necessary medical treatment , or procedures, including diagnostic x-ray, local anesthesia, drugs, and supplies as may be ordered by the attending physician(s), his assistants or designees. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment or diagnostic procedures conducted in the Imaging Center.

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

† **LIFETIME MEDICARE B SIGNATURE AUTHORIZATION:** I authorize any holder of medical or other information about me to release to the Social Security Administration and center for Medicare & Medicaid Services or it's intermediaries or carriers, or to the billing agent of the Imaging Center any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits be made to the holder of this assignment on my behalf. I understand that I am responsible for any deductible and coinsurance.

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

**IF PATIENT IS UNDER 18: I hereby give my permission for \_\_\_\_\_ to be treated at the Imaging Center.**

In accordance with city, state, and federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), **Carlsbad Imaging Center** will protect patient records and other information that may reveal a patient's identity when using or disclosing such information for purposes of treatment, payment, or health care operations. I am aware that I can request to review the policy of **Carlsbad Imaging Center** for patient's privacy.

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