WESTCHESTER NEUROLOGICAL CONSULTANT, PC

970 N Broadway Suite 107 • Yonkers NY 10701
20 Cedar Street Suite 107 • New Rochelle NY 10801
Phone: (914) 966-0505 • Fax: (914) 966-0515

WORKERS' COMPENSATION PATIENT INTAKE PACKET

SECTION 1 — PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

Cell Phone: _____ Home Phone: _____

Email Address: _____

SECTION 2 — WORKERS' COMPENSATION CLAIM INFORMATION

Date of Injury: _____ State Where Injury Occurred: _____

Employer Name: _____ Employer Phone: _____

Employer Address: _____

Insurance Carrier: _____

WCB Case Number: _____ Claim Number: _____

Approved Body Part(s): _____

☐ Head ☐ Neck ☐ Back ☐ Shoulder ☐ Arm ☐ Hand ☐ Leg
☐ Other: .....

Authorization Status: ☐ Approved ☐ Pending ☐ Unknown

SECTION 3 — ADJUSTER INFORMATION

Adjuster Name: _____ Adjuster Phone: _____

Adjuster Email: _____

SECTION 4 — ATTORNEY INFORMATION

Attorney Name: _____ Law Firm: _____

Phone Number: _____ Email Address: _____

➔ **ALL PAGES MUST BE COMPLETED**

SECTION 5 — PRIOR MEDICAL & TESTING HISTORY

Have you had neurological testing already? ☐ Yes ☐ No

If YES, check all completed tests:

☐ MRI Brain ☐ MRI Spine ☐ EMG/NCS ☐ EEG ☐ VNG ☐ Neuropsychological Testing

☐ Other: _____

Facility Name & Phone Number: _____

Date(s) Performed: _____

SECTION 6 — IMPORTANT OFFICE POLICY

✔ Patients must provide complete Workers' Compensation information prior to the visit.
✔ Failure to provide claim or adjuster information may result in appointment cancellation.
✔ This office provides neurological evaluation and treatment. Patients referred solely for disability certification after outside testing may not be scheduled.
✔ Authorizations are the responsibility of the carrier and legal representatives.

SECTION 7 — PATIENT ACKNOWLEDGMENT

I certify that the above information is accurate and complete. I understand that incomplete Workers' Compensation information may delay treatment or result in rescheduling.

Patient Signature: _____ Date: _____

SECTION 8 — HIPAA ACKNOWLEDGMENT

I acknowledge receipt of the Notice of Privacy Practices.

Patient Signature: _____ Date: _____

SECTION 9 — ASSIGNMENT OF BENEFITS

I authorize payment of Workers' Compensation medical benefits directly to Westchester Neurological Consultant, PC for services rendered.

Patient Signature: _____ Date: _____

SECTION 10 — MISSED APPOINTMENT POLICY

Patients must provide 24-hour notice for cancellations. Repeated no-shows may result in discharge from the practice.

Patient Signature: _____ Date: _____

➔ **ALL PAGES MUST BE COMPLETED**

➔ **ALL PAGES MUST BE COMPLETED**