

**MARK D. EPSTEIN, M.D., F.A.C.S.**

**Worker's Compensation**

Were you injured on the job? \_\_\_\_\_ Date of injury: \_\_\_\_\_

Are you still working? \_\_\_\_\_ If no, last date worked: \_\_\_\_\_

Worker's Compensation carrier: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Claim #: \_\_\_\_\_

Policy #: \_\_\_\_\_

WCB #: \_\_\_\_\_

Employer at the time of injury: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize payment of Worker' compensation benefits directly to Mark D. Epstein, M.D. In the event that I fail to file a claim for Worker' compensation benefits for this illness or condition, or it is determined by the Worker' compensation carrier that the illness or condition is not a result of a compensable Worker' compensation case, I hereby agree to pay Mark D. Epstein, M.D. his usual and customary fees for all services rendered.

I HEREBY AUTHORIZE MARK D. EPSTEIN, M.D. TO RELEASE INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO BE RELEASED TO MY WORKER' COMPENSATION CARRIER AND/OR MY ATTORNEY.

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

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