Main Office
9080 Harry Hines Blvd.
Suite 220
Dallas, Texas 75235
Phone: (214) 351-8450
Fax: (214) 366-3713

Feigenbaum Neurosurgery, P.A.
Frank Feigenbaum, M.D., FAANS
Specializing in spinal neurosurgery & the treatment of meningeal cysts
frankfeigenbaum.com

Kansas Office
12330 Metcalf Avenue
Suite 500B
Overland Park, Kansas 66213
Phone: (214) 351-8450
Fax: (214) 366-3713

WORKERS COMPENSATION CLAIM

Name_____**DOB**_____ **Date** _____

HAS THIS VISIT BEEN AUTHORIZED BY YOUR WORKERS COMPENSATION CARRIER? _____

Employer Information

Employer_____ **Employer Phone #**_____

Employer's Address _____

Person to contact at your employer_____ **Phone#**_____

Workers Compensation Insurance Carrier

Name of insurer_____ **Phone#** _____

Address_____

Contact person_____**CLAIM #** _____

Date of injury_____ **First date of disability** _____

How were you injured? _____

_____

Have you had previous treatment for this injury? _____ **If yes, when and where?** _____

_____

Previous x-rays?_____ **CAT scan?** _____ **MRI scan?** _____

Referring physicians name _____

Attorney's name _____ **Phone** _____

I authorize the release of medical information to my workers compensation insurance carrier. I understand that if my consultation or treatment has not been approved, I will be responsible for the charges.

_____
Signature **Date**

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WORKER'S COMPENSATION/AUTOMOBILE RELEASE

August 1, 2016

Dear Patient,

Feigenbaum Neurosurgery, P.A. has discussed with you on the phone our medical practice policy of not accepting Worker's Compensation and/or Automobile Injury patients.

We understand based on our conversation with you, that your possible diagnosis of symptomatic Tarlov cysts is not currently related to your filed Worker's Comp and/or auto claim(s).

Our medical practice policy requires that you agree, in writing, prior to scheduling your initial consultation, that any medical claims related to your medical visit for symptomatic Tarlov cysts, will not be included in any current or future Worker's Comp and/or auto claim(s).

When you return this signed document, we will schedule you for an initial consultation visit, for Dr. Feigenbaum to review your MRI and perform a physical examination. We will bill your commercial insurance for this consultation and any surgical treatments that may be medically necessary. In the event that your commercial insurance refuses to pay, then you will be responsible for medical services, as a self-pay patient.

Your signature is your acknowledgement that you have read and agree with Feigenbaum Neurosurgery's medical practice policy outlined in this letter.

If you have any questions, do not hesitate to call.

Sincerely,

Laura Abshire
Office Manager
Feigenbaum Neurosurgery, P.A.
214-351-8450 option 5

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WORKER'S COMPENSATION/AUTOMOBILE RELEASE

Date: _____

Patient Name: _____

DOB: _____

I, _____ (patient name), agree that I will not pursue worker's compensation and/or automobile liability claims before or after my services are rendered with Feigenbaum Neurosurgery, P.A. This includes any legal consultations such as depositions, IMEs, letters, or communications with any legal representation on behalf of the patient. Medical records will only be provided upon written request with patient's signed release.

I, _____ (patient name), agree that any medical services will be billed to my commercial insurance carrier. If my insurance company decides to deny services, I will be financially responsible and will be considered a self-pay patient. It is my responsibility to keep in contact with staff regarding any denied claims. If I do not have insurance, I will be self-pay, and a payment plan will be determined before services are rendered.

Your signature is acknowledgement that you have read and agree with Feigenbaum Neurosurgery's medical practice policy.

Patient Signature: _____ Date: _____

Witness Signature: _____

Witness Name: _____

Relation: _____ Date: _____