WORK COMP QUESTIONIARE

Claim #_____

Adjuster's Name_____ Adjuster's Phone #_____

1. What was the date of the injury? _____
2. About what time did the injury occur? _____
3. What is the name of your employer? _____
4. What is the street address of your employer? _____
5. What are the City, State, and Zip of your employer? _____
6. What is the name of your attorney? _____
7. What is the street address of your attorney?_____
8. What are the City, State, and Zip of your attorney?_____
9. Please describe your incident in a few sentences:

   _____

   _____

   _____

10. Did you report the incident to your supervisor? Yes No
11. What is your Supervisor's name? _____
12. Did your employer send you to a doctor? If yes, please provide the doctor's information

    _____

13. Did you go to a doctor on your own? If yes, please provide the doctor's information

    _____

14. Are there any other problems that affect your employment?

    _____

    _____

15. Does your job cause you to favor one side of your body?_____
16. Before injury, were you capable of performing equal work with others your age? Yes No
17. Have your injured this area before? Yes No

LIEN FORM

I do hereby authorize Dr. Steven Saro to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered to me both by reason of this accident and by reason of any other bills that are due to his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I herby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payments on a current basis.

PATIENT'S SIGNATURE _____ **DATED** _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums for any settlement, judgment, or verdict, as may be necessary protect said doctor.

ATTORNEY'S SIGNATURE _____ **DATED** _____