WORKERS COMPENSATION / THIRD PARTY INSURANCE INFORMATION SHEET

DR SAM CHIA

Patient Name .....

Date of injury ..... Claim No .....

INSURANCE COMPANY .....

ADDRESS .....

..... POSTCODE .....

CONTACT .....

PHONE ..... FAX .....

EMPLOYER .....

ADDRESS .....

..... POSTCODE .....

CONTACT .....

PHONE ..... FAX .....

SOLICITOR .....

ADDRESS .....

..... POSTCODE .....

CONTACT .....

PHONE ..... FAX .....

I hereby give my permission for Dr Sam Chia to release my personal details to either my Employer or the Insurance Company.

I also undertake to pay all fees to Dr Sam Chia in the event of liability being denied by the Insurers.

Print Name ..... Signature ..... Date.....