To our patients:

We understand that you are being seen by the physician today for injuries that you sustained while employed. In compliance with our workers' compensation policy, it is your responsibility to get the following information to us **within seven (7) days or we will be forced to bill YOU** for services. We appreciate your cooperation with this matter.

Patient Name:_____
MRN #:_____

Name of Caseworker:_____
Phone number of Caseworker:_____

Name of Insurance Carrier for Employer:_____
Phone number of Carrier:_____
Fax number for Carrier:_____

(Attach business card of contact person)

Call information to our Medical Records Department at **(402) 354-0760** or **Fax** information to **(402) 354-0738.**