

SOUTHERN WESTCHESTER ORTHOPEDICS & SPORTS MEDICINE ASSOCIATES, P.C.
970 NORTH BROADWAY-SUITE 204
YONKERS, NEW YORK 10701
TELEPHONE: (914) 476-4343
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DAVID E. LENT, M.D., F.A.A.O.S.
ERIC M. SPENCER, M.D., F.A.A.O.S.

WORKER'S COMPENSATION

DATE: _____
NAME: _____ DOB: _____ SOC. SEC. # _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
HOME PHONE: _____ CELL PHONE: _____ OFFICE PHONE: _____
EMAIL: _____
PREFERRED METHOD OF CONTACT: _____
NAME AND PHONE OF PHARMACY: _____

EMPLOYER

EMPLOYER NAME: _____
EMPLOYER ADDRESS: _____
EMPLOYER TELEPHONE: _____ OCCUPATION: _____
HUMAN RESOURCE'S NAME AND NUMBER: _____

WORKER'S COMPENSATION CARRIER

WORKER'S COMPENSATION CARRIER: _____
CARRIER ADDRESS: _____
CARRIER PHONE NUMBER: _____ FAX NUMBER: _____
ADJUSTOR'S NAME: _____ CLAIM NUMBER: _____
W.C.B. CASE #: _____

INJURY INFORMATION

DATE OF INJURY: _____ ACCIDENT REPORTED: _____
PLACE OF INJURY: _____

PLEASE GIVE FULL DESCRIPTION OF HOW ACCIDENT HAPPENED:

WHAT BODY PART WAS INJURED? RIGHT _____ LEFT _____
HAVE YOU LOST TIME FROM WORK? _____ LAST DAY WORKED: _____
ARE YOU WORKING AS OF TODAY? _____

PATIENT SIGNATURE: _____ DATE: _____

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)		CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.
CLAIMANT	NAME			ADDRESS	APT. NO.
EMPLOYER					
INSURANCE CARRIER					

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature _____ Date _____

Provider's Name and Address SOUTHERN WESTCHESTER ORTHOPEDICS & SPORTS MEDICINE
970 North Broadway Yonkers, NY 10701

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.

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David E. Lent, MD, F.A.A.O.S.
Eric M. Spencer, MD, F.A.A.O.S.

NAME: _____

WERE YOU TREATED IN THE EMERGENCY ROOM? _____ WHEN: _____
WHERE: _____

PAST MEDICAL HISTORY: _____

DO YOU HAVE ANY ALLERGIES? _____

MEDICATION YOUR ARE CURRENTLY TAKING: _____

HEIGHT: _____ WEIGHT: _____

I also authorize the release of any medical information to my Primary Care Physician and or insurance company. I also certify that I have read and have been given a copy of Southern Westchester Orthopedics & Sports Medicine Assoc., PC's notice of Privacy Practices describing how my medial information may be used and disclosed and how I can access my medical information.

SIGNATURE: _____