# ***WORKERS' COMPENSATION INFORMATION***

**Patient** Name: _____ Date of Birth: _____ Date: _____

Please state body part injured: ( ) Right ( ) Left _____

Where did injury occur? City: _____ State: _____ Date of injury: _____

Are you currently out of work due to injury? ( ) Yes ( ) No

Job Title: _____ Job Duties on day of injury: _____

_____

**Employer** Name: _____ Supervisor: _____

Address: _____ City/State/Zip: _____

Employer Phone: _____

Have you filed a report with your employer? ( ) Yes ( ) No

**Insurance** Carrier: _____ Carrier ID# **W**_____

Address: _____ City/State/Zip: _____

Insurance Carrier Phone: _____

Adjuster's Name:_____ Adjusters Phone: _____

Carrier Case #: _____ Workers' Compensation Board #: _____

If at this time a Case Number and/or WCB Number has not been assigned to you, we must submit all paperwork under your Social Security Number _____. Please inform the office when your case numbers are received so that we can update your records.

I hereby authorize Regional Orthopaedics & Pain Management, PLLC to furnish my attorney copies of my medical reports, bills, and any other pertinent data that pertains to my condition resulting from the injuries sustained on the above-mentioned date of injury.

I hereby authorize and direct my attorney to withhold the amount of the physician's bill from any monies collected on my behalf, and forwarded to the said physician before or on the settlement of my case. I understand that this does not relieve me of my obligation to pay the physician's bill and other bills relating to this case. This assignment is irrevocable.

In the event my compensation claim is denied for payment, I understand that I will be responsible for any and all charges incurred.

**Attorney Information:**
**DO YOU HAVE AN ATTORNEY REPRESENTING YOU FOR THIS INJURY?**
**____Yes ____No ____Not at the present time, but I intend to seek legal counsel for this case**

If you do have an attorney for this accident/injury, please furnish the information requested below:

Attorney Name: _____ Phone: _____ Fax: _____

Address: _____ City/State/Zip: _____

*AGREEMENT TO PAY MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE OR IF COMPENSATION CLAIM IS DISALLOWED*

In the event I fail to prosecute the claim for workers' compensation for this illness or condition or it is determined by the Workers' Compensation Board that the illness or condition is not a result of a compensable workers' compensation case, I _____, hereby agree to pay Regional Orthopaedics & Pain Management, PLLC with the following location 75 Crystal Run Road, Suite 206 Middletown, NY 10941 his/her usual and customary fees for services rendered to the above named claimant in the above identified case.

Date: _____ Signature: _____

If signed by other than claimant, print the name, address, and relationship of signer

Name and Address: _____Relationship: _____