ORTHOPAEDIC ASSOCIATES OF ROCHESTER, P.C.
WORKERS' COMPENSATION INFORMATION FORM

Patient Name: Last _____ First _____ MI ____
Address_____ Home phone _____
City, State, Zip _____ Cell phone _____

Patient Date of Birth _____ Social Security # _____

Date of Injury: _____ Date reported to employer_____

Workers Comp Board Number:_____
Carrier Case Number: _____

Employer:_____ Phone _____
Employer address _____
_____
Employer's Insurance Company _____
Employer's Ins.Co. Address _____
_____

I, the undersigned, hereby authorize payment directly to Orthopaedic Associates of Rochester, PC, for any benefits for medical expenses or other indemnity that I may be entitled to. I hereby give permission to OAR,PC, to release information, if requested, to my primary care physician, hospitals, insurance carrier or Workers Compensation carrier for coordination of benefits.

I understand that I am financially responsible for charges not covered by this assignment, and that my failure to provide the necessary information to OAR, PC, within TEN days will make me personally responsible for charges related to this injury.

In the event that I fail to prosecute the claim for Workers' Compensation for this condition, or it is determined by the Workers' Compensation Board that this condition is not a result of a compensable Workers' Compensation case, I hereby agree to pay Orthopaedic Associates of Rochester, PC, 2410 Ridgeway Avenue, Rochester, NY 14626, their usual and customary fees for services rendered to me in this case. Or, if applicable, the claim will be sent to my primary insurance company for payment with the proper notice of decision.

Date_____ Patient Signature _____

If signed by other than claimant, print name, address, and relationship of signer:
PRINT name _____ relationship _____
Address of signer, if not patient _____