South Island Orthopedics, P.C.

657 Central Avenue
Cedarhurst, NY 11516
T: 516-295-0111
F: 516-295-9438

205 Froehlich Farm Blvd
Woodbury, NY 11797
T: 516-364-0070
F: 516-364-0242

PATIENT REGISTRATION FORM (Please Print)

Today's Date:	**Thank you for selecting South Island Orthopedics, P.C.**

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Gender:	Age:

Patient's Birth Date: mm/dd/yyyy	Marital Status: S M D W SEP	Social Security:	Preferred Language:

Street Address:	Apt #	City/Town:	State:	Zip Code:	Home Phone Number:

Mobile Phone Number:	Work Phone Number:	Email Address:	Preferred Method of Contact: ☐ Home ☐ Mobile ☐ Work ☐ Email

Name of Employer:	Address:	City/Town:	State:	Zip:

SPOUSE INFORMATION

Last Name:	First:	Contact Number:

EMERGENCY CONTACT

Name:	Relationship to Patient:
Primary Telephone Number:	Secondary Telephone Number:

REFERRAL SOURCE	Primary Care Physician
How did you learn about us? Internet ☐ Friend/Family ☐ Physician☐ Attorney ☐ Other ☐	Primary Care Physician Name:
Please list the name and number of the referral source:	Street Address:
	City, State, Zip:
	Telephone Number:

PHARMACY INFORMATION

Name (Local):	Address:	Telephone #:	Fax#:
Name (Mail Away):	Address:	Telephone #:	Fax#:

HEALTH INSURANCE INFORMATION

Primary Insurance: Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Insurance Name:	Group Number:
	ID Number:
Insured's Name (if not self, spouse or parent listed above):	Birth Date:

Secondary Insurance: Patient's Relationship to Insured: Self Spouse Child Other:

Secondary Insurance Name:	Group Number:
	ID Number:

Insured's Name (if not self, spouse or parent listed above):	Birth Date:

SYMPTOM SPECIFICATIONS (Give only a brief description in one to two sentences)

Please list your symptoms and complaints relating to your visit today:

PATIENT REGISTRATION FORM CONTINUED (Please Print)

MEDICAL TREATMENT HISTORY

Are these symptoms related to an accident? ☐ YES ☐ NO

Did you go to the hosptial? ☐ YES ☐ NO	If yes, list hopsital name:
Were you: ☐ Out-Patient ☐ In-Patient	Any X-Rays/MRI's or testing performed?
Have you seen any doctors for this inury and/or condition: ☐ YES ☐ NO	If yes, what type?

Medication(s) Prescribed:

NO FAULT MOTOR VEHICLE ACCIDENT

Insurance Company Name:	Insurance Phone Number:
Policy Holder Name:	Claim Representative:
Claim #:	Policy#

Was the accident reported to the insurance company? ☐ YES ☐ NO

Was the accident reported to the police? ☐ YES ☐ NO **(If yes, provider the front desk with a copy of the police report.)**

Where you the: ☐ Driver ☐ Passenger ☐ Pedestrian

# of people in the Vehicle:	Where was the vehicle hit? ☐ Front ☐ Rear ☐ Driver Side ☐ Passenger Side

Were you working at the time of accident? ☐ YES ☐ NO

WORKERS COMPENSATION-WORK ACCIDENT

Insurance Carrier:	Employer Name & Address (at the time of accident)
Claim/Carrier Case #:	
WCB #:	
Claim/Case Manager:	Telephone Number:

Was injury reported to your employer? ☐ YES ☐ NO

Name & Phone number of Supervisor Reported to:

Injury Specifications

Date of Injury:	Accident occurred in: City:	State:

Injury resulted from: ☐ Motor Vehicle Accident ☐ Work Accident ☐ Other

- If other please specify:

Do you have an attorney representing you for this injury? ☐ YES ☐ NO

Attorney Firm Name:		Telephone Number:
Did you miss any time at work as a result of the injury? ☐ YES ☐ NO	1st Date Missed:	Date of Return:

PATIENT/GUARDIAN SIGNATURE: ____________________ **DATE:** ______/______/______

IF GUARDIAN, PRINT RELATIONSHIP TO PATIENT: ____________________

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Patient Permissions and Preferences Form

Patient Name:____ **Date of Birth:** ___________________

Last **First** **MI**

I authorize **South Island Orthopedics, P.C.,** to discuss my health information with the following personal representative(s).

Name:	Relationship:	Telephone:
Name:	Relationship:	Telephone:

☐ I decline at this time to list a personal representative to discuss my health information.

PATIENT AUTHORIZATION -AUTHORIZATION TO CALL

It is the policy of **South Island Orthopedics, P.C.,** to confirm appointments via telephone or in some cases with an automated appointment confirmation service.

I wish to be contacted in the following manner (Check all that apply):

Home Telephone:________________________________

☐ OK to leave message with detailed information*
☐ OK Leave message with call back number only

Cell Phone: ___________________________________

☐ OK to leave message with detailed information*
☐ Leave message with call back numberonly

Written Communication

☐ OK to mail home address
☐ OK to mail to my work/office address (provide address)
☐ OK to fax to this number __________________________

Work Telephone: ______________________________

☐ OK to leave message with detailed information *
☐ Leave message with call back number only

Other:
☐ OK to text (text messaging fees may apply)

Patient/Patient Representative signature: _____________________________ Date: _________________________
Print Name (if **other than patient):** ____
Relationship to Patient: ____

*detailed information may include but is not limited to: lab results, diagnosis, treatment instructions

PLEASE NOTE, THE ABOVE INFORMATION WILL BE IN EFFECT UNTIL YOU REVOKE IT IN WRITING TO THE PRACTICE

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Medical History Questionnaire

Name: **Age:** **Date of Birth:**

Hand Dominant ☐ **Right** ☐ **Left** **Date of Injury:** _____________ **Height:** __________ **Weight:** __________

Chief Complaint: please describe, in detail, your current injury or complaint (which limb, initial symptoms, aggravating activities)

Past Medical History: (i.e., diabetes, high blood pressure, kidney, liver, heart problems)

Present Medication: please list all the medications and supplements you are taking or have taken in the last month

Allergies: please list allergies to food or medication

Past Surgeries/Illness/Accidents and Hospitalizations:

Family History:

Father: AGE _____ ☐ Living ☐ Deceased ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke
Other:

Mother: AGE _____ ☐ Living ☐ Deceased ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke
Other:

Review of Systems: Have you ever been diagnosed by a physician with any of the following?

Head and Neck
☐ Severe Headaches ☐ Double Vision ☐ Swelling in Neck ☐ Dizzy Spells ☐ Difficulty Hearing
☐ Fainting ☐ Failing Vision ☐ Prolonged Hoarseness ☐ Stroke

Heart and Lungs
☐ Chest Pain ☐ High Blood Pressure ☐ Pneumonia ☐ Heart Attack ☐ Difficulty Breathing
☐ Skipping Heart Beats ☐ Chronic Cough/TB ☐ Ankles Swell ☐ Heart Defects/Murmurs

Stomach and Intestines
☐ Persistent Nausea ☐ Diabetes ☐ Stomach Ulcers ☐ Heartburn Regularly ☐ Hepatitis/Jaundice
☐ Black or Blood in stool ☐ Appetite Loss ☐ Hemorrhoids ☐ Chronic Diarrhea/Constipation

Urinary Tract-etc.
☐ Excess Urination ☐ Urinary Problems ☐ Painful/Excess Menstruation ☐ Difficulty Urination
☐ Passes any Stone ☐ Bleed Between Periods ☐ Blood in Urine ☐ Retention of Urine ☐ Pregnancies # ______

Muscle Joints Nerves
☐ Tingling Sensations ☐ Memory Loss ☐ Seizures ☐ Numbness ☐ Personality Changes
☐ Depression ☐ Disturbance in Walking ☐ Paralysis ☐ Varicose Veins ☐ Muscle Jerking
☐ Speech Disturbance

Other:
☐ Skin Disorders ☐ Bleeding Disorders ☐ EBV ☐ CMV ☐ HIV
☐ Thyroid Disorder ☐ ALL OTHER NEGATIVE

Occupation/Position:
Do you smoke or have you been a smoker? ___________ __________ packs per day x __________ years
Do you drink alcohol? ___________ How Much? ___________ Non-Prescribing drug use _________________________________

Date Reviewed ___________ Physician's Signature ____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
South island Orthopedics, P.C. 205 Froehlich Farm Blvd, Woodbury, NY 11797

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) ________________ to (insert date) ________________
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: ______________________________

Include: (*Indicate by Initialing*)

________ **Alcohol/Drug Treatment**

________ **Mental Health Information**

________ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here __________ I authorize ______________________________________

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

______________________________ Date: ____________________

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Workers' Compensation Board

CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

(Pursuant to Workers' Compensation Law Section 110-a)

PO Box 5205, Binghamton, NY 13902-5205 ● www.wcb.ny.gov

CLAIMANTS ARE PROHIBITED FROM AUTHORIZING RELEASE OF WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT.

PLEASE COMPLETE ALL ITEMS. AN INCOMPLETE FORM WILL DELAY THE PROCESSING OF YOUR REQUEST.

Claimant's Name	Claimant's Social Security or Tax Identification Number	Case Number ☐ WCB ☐ DB ☐ Discrimination ☐ PFL and/or Date of Accident

IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC/PFL CASE NUMBER AND/OR DATE OF ACCIDENT(S)

INSTRUCTIONS:

Submit original to the Workers' Compensation Board and retain a copy for your records. *Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form.* This authorization is effective until it is revoked by the claimant. Claimant may revoke this authorization at any time upon written notice to the Workers' Compensation Board.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO OPEN AN INDIVIDUAL eCASE ACCOUNT OR TO VIEW CASES VIA eCASE OUTSIDE OF A BOARD LOCATION.

Pursuant to Section 110-a of the Workers' Compensation Law, I, ______________________________,
(CLAIMANT'S NAME)

represent that I am a person who is/was the subject of the workers' compensation cases(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to ______________________________,
(NAME OF A SPECIFIC PERSON, CORPORATION, ASSOCIATION OR PUBLIC OR PRIVATE ENTITY)

at ______________________________.
(ADDRESS)

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

______________________________ ______________

Claimant's Signature (ink only - use blue ink if possible) Date

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.

Employee Claim

C-3

State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

WCB Case Number (if you know it): ____________________

A. YOUR INFORMATION (Employee)

1. Name: ______________________________ (First, MI, Last) 2. Date of Birth: ____/____/____
3. Mailing address: ______________________________ (Number and Street/PO Box/Apartment No., City, State, Zip Code)
4. Social Security Number: ___ - ___ - ___ 5. Phone Number: (____)__________ 6. Gender: ☐ Male ☐ Female
7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? __________

B. YOUR EMPLOYER(S)

1. Employer when injured: ______________________________ 2. Phone Number: (____)__________
3. Your work address: ______________________________ (Number and Street, City, State, Zip Code)
4. Date you were hired: ____/____/____ 5. Your supervisor's name: __________
6. List names/addresses of any other employer(s) at the time of your injury/illness: __________

____

____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? __________
2. What types of activities did you normally perform at work? __________

____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: __________
4. What was your gross pay (before taxes) per pay period? __________ 5. How often were you paid? __________
6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: __________

____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ____/____/____ 2. Time of injury: __________ ☐ AM ☐ PM
3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) __________

____

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? __________

____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) __________

____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) __________

____

____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): __________

____

____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

YOUR NAME:______________________________ DATE OF INJURY/ILLNESS: ____/____/____
First MI Last

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? ______________

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
 If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): ______________
 If your vehicle was involved, give name and address of your motor vehicle insurance carrier: ______________

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
 If yes, notice was given to: ______________ ☐ orally ☐ in writing Date notice given: ____/____/____

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: ______________

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? ____/____/____ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? ____/____/____ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? ______________ How often are you paid? ______________

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? ____/____/____ ☐ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room
 ☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
 Name and address where you were first treated: ______________
 ______________ Phone Number: (____)______________
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
 Give the name and address of the doctor(s) treating you for this injury/illness: ______________
 ______________ Phone Number: (____)______________
5. Have you had another injury to the same body part, or a similar illness? ☐ Yes ☐ No
 If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
 ____
 ____
 ____
6. Was the previous injury/illness work related? ☐ Yes ☐ No
 If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: ______________ Print Name: ______________ Date: ____/____/____

On behalf of Employee: ______________ Print Name: ______________ Date: ____/____/____

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): ______________ Date: ____/____/____

Print Name: ______________ Title: ______________

ID No., if any: **R** ______________ If Licensed Representative, License No.: ______________ Expiration Date: ____/____/____

Workers' Compensation Board

Limited Release of Health Information
(HIPAA)

State of New York - Workers' Compensation Board

C-3.3

WCB Case No. *(if you know it)*:__________________________

To Claimant: If you received treatment for a *previous* injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your previous injury/illness to your employer's workers' compensation insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) says you have a right to get a copy of this form. If you do not understand this form, talk to your legal representative. If you do not have a legal representative, the Advocate for Injured Workers at the Workers' Compensation Board can help you. Call: 800-580-6665.

To Health Care Provider: A **copy** of this HIPAA-compliant release allows you to disclose health information. If you send records to the employer's workers' compensation insurer in response to this release, also mail copies to the Claimant's legal representative. (If no legal representative is listed below, send copies to the Claimant.) Health care providers who release records must follow New York state law and HIPAA.

This release is:

- **Voluntary.** Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- **Limited.** It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- **Temporary.** It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- **Revocable.** You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's workers' compensation insurer and the Workers' Compensation Board. *Note: You may not cancel this release with respect to medical records already provided.*
- **For records only.** It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's workers' compensation insurer.

This form does NOT allow your health care provider(s) to release the following types of information:

- **HIV-related information**
- **Psychotherapy notes**
- **Alcohol/Drug treatment**
- **Mental Health treatment** (unless you check below)
- **Verbal information** (your health care providers may not discuss your health care information with anyone)

Any medical records released will become part of your workers' compensation file and are confidential under the Workers' Compensation Law.

A. YOUR INFORMATION (Claimant)

1. Name:____________________ 2. Social Security Number:______-_____-______
3. Mailing Address: ____________________
4. Date of Birth: ______/______/______ 5. Date of the current injury/illness: ______/_______/_______
6. Current injury/illness, including all body parts injured:____________________
7. Your legal representative's name and address (if any):____________________

☐ *Check here if you allow your health care provider(s) to release **mental health care** information.*

B. YOUR HEALTH CARE PROVIDER(S)

(List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers attach their contact information to this form.)

1. Provider:____________________ 2. Phone Number: (______)______________
3. Mailing Address: ____________________
4. Other provider (if any):____________________ 5. Phone Number: (______)______________
6. Mailing Address:____________________

C. READ AND SIGN BELOW.

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

____
Claimant's signature (ink only -- use blue ballpoint pen, if possible.) Date

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below:

____
Your name Relationship to Claimant Signature (ink only -- use blue ballpoint pen, if possible.) 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 ____

____

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.

South Island Orthopedics, P.C.
657 Central Avenue Cedarhurst NY 11516

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the HIPAA Notice of Privacy Practices.

____

Signature

____

Printed Name

____

Date

If representative's signature appears above please list patient name and relationship to patient:

____

Patient Name

____

Relationship to Patient