Printed on : txt_date|DA

Patient Information

Personal Information

First Name	txt_fname|FirstName	**Middle Name**	txt_mname|MiddleName
Last Name	txt_lname|LastName	**D.O.B**	txt_dob|DOB
Gender	txt_sex|Sex	**Address**	txt_address|Address1
City	txt_city|City	**State**	txt_state|State
Cell Phone #	txt_mob|Phone2	**Home Phone**	txt_Phone2|Phone
Work		**Zip**	txt_zip|Zip
Email		**Extn.**	Text12
Attorney	txt_attorney|Attorney	**Case Type**	txt_casetype|Compensation
Attorney Address	txt_attorneyAdd|AttorneyAdd	**Attorney Phone**	txt_attorneyPhno|AttorneyPhno
Case Status		**SSN**	txt_ssn|SSN

Insurance Information

Policy Holder	txt_name123|patientfullname	**Name**	txt_InsCo|InsCo
Address	txt_Insaddress987|InsAddress1		txt_Inscity
State		**Zip**	txt_Inszip|Inszip
Phone	txt_InsPhone987|InsTelephone	**Fax**	
Contact Person		**Claim File #**	txt_ClaimNumber|ClaimNumber
Policy #			

Accident Information

Accident Date	txt_doa|DOA	**Plate Number**	
Report Number		**Address**	
City		**State**	
Hospital Name		**Hospital Address**	
Date of Admission		**Additional Patient**	
Describe Injury		**Patient Type**	

Employer Information

Name		**Address**	
City		**State**	
Zip		**Phone**	
Date of First Treatment		**Chart #**	

Adjuster Information

Name	txtAdjuster|AdjUserName	**Phone**	txtAdjusterph|AdjPhone
Extension		**Fax**	
Email			

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.
		txt_doa|DOA		

CLAIMANT	NAME txt_name|patientfullname	ADDRESS txt_address|Address1	APT. NO.
EMPLOYER		txt_city|City	txt_state|State
INSURANCE CARRIER	txt_InsCo|InsCo	txt_zip|Zip	

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 txt_date|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.

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
txt_name|patientfullname	txt_dob|DOB	txt_ssn|SSN
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:

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:	11. Date or event on which this authorization will expire:
☐ At request of individual ☐ Other:	
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: txt_date|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 INSURANCE FORM

PATIENT INFORMATION

NAME: txt_name|patientfullname

SS #: txt_ssn|SSN

ADDRESS: txt_address|Address1

BIRTHDATE: txt_dob|DOB

txt_city|City txt_state|State txt_zip|Zip

PHONE #: txt_mob|Phone2

EMPLOYMENT INFORMATION

EMPLOYER: _____

CONTACT: _____

ADDRESS: _____

PHONE #: Text12

_____

DATE OF INJURY: txt_doa|DOA

HOW DID INJURY OCCUR? _____

_____

WORKERS COMPENSATION INSURANCE CO. INFORMATION

INSURANCE CO. NAME: txt_InsCo|InsCo

CONTACT: _____

ADDRESS: txt_Insaddress|InsAddress1

PHONE #: _____

txt_Inscity txt_Insstate|InsState txt_Inszip|Inszip

CC #: _____

LEGAL REPRESENTATIVE: _____

WCB #: _____

PHONE #: _____

_____

AUTHORIZATION

I hereby authorize **UK Sinha Physican** to release information obtained during the course of any examination and treatment to my authorized worker's compensation insurance carrier for the above-described injury. I hereby assign payment directly to **UK Sinha Physican** for any medical services rendered. I understand that I am responsible for payments for all services rendered and any associated costs for collection should such action become necessary if worker's compensation coverage were denied for any reason. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy of this assignment shall be considered as valid as the original. I have read the above and fully understand the terms thereof:

txt_name|patientfullname		txt_date|DATE
PRINT NAME	SIGNATURE	DATE/TIME

I hereby authorize **UK Sinha Physican** to release information to anyone requestion information in regard to my worker's compensation claim over the telephone and identifying themselves as a representative of my worker's compensation carrier.

txt_name|patientfullname		txt_date|DATE
PRINT NAME	SIGNATURE	DATE/TIME

I certify that the information given by me in regard to worker's compensation is correct. To the best of my knowledge, the claim is active at the time of signature. I also understand that I may be responsible for payment of coverage not covered by the worker's compensation program.
I hereby give my permission for my charges to be submitted to by private medical insurance carrier if the worker's compensation claim is denied or found to be invalid.