

WORK INJURY INFORMATION

Falanga Family Chiropractic
4 Butternut Drive
Oswego, NY 13126
(315) 343-2961 (315) 343-4001 fax

Date _____

Patient Information

Name _____ Birth Date _____ Soc. Sec. # _____

Address _____
Street City State Zip

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Email Address _____ Occupation _____

Employer Information

Employer Name _____

Employer Address _____
Street City State Zip

Employer Phone (____) _____ Contact Person _____

Email Address _____

Worker Compensation Carrier Information

Carrier Name _____

Carrier Address _____
Street City State Zip

Carrier Phone (____) _____ Claim Number _____

Adjuster's/Case Worker's Name _____

Injury Information

Date of Injury _____ Time _____ am / pm Place of Injury _____

Accident reported to employer? **Yes / No** Name of person you reported accident to _____

Give FULL description of how the accident happened _____

Have you lost time from work? **Yes / No** How much? _____

List other doctors seen for this condition: _____

Were X-rays taken? **Yes / No** Other tests? **Yes / No**

If yes please list the tests and where the tests were taken: _____

Have you had previous work injuries? **Yes / No** Dates of those injuries _____

Please describe previous work injuries _____

Authorization

I attest that the above information is complete and correct to the best of my knowledge:

Signature of Patient, Parent or Personal Representative Date

Please print name of Patient, Parent or Personal Representative Relationship to Patient

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.