Jared F. Brandoff, M.D. Paul Fragner, M.D. Dov Kolker, M.D. Daniel Markowicz, M.D. Michael Schwartz, M.D. Eric Zitzmann, M.D.



Orthopaedic Specialists 222 Westchester Avenue Suite 101 West Harrison, NY 10601

WORKERS COMPENSATION INTAKE FORM

I hereby authorize payment directly to WHITE PLAINS HOSPITAL for services rendered relating to an accident/injury covered under Workers Compensation insurance benefits.

I hereby authorize the provider of these services to release any medical records relating to my claims to my insurer liable for payment of such claim.

In the event the provider's charges are outstanding and / or fail to file an application for benefits under New York State Insurance law, I understand that I am personally responsible for the payment of the charges related to my claim.

Patient's Name		Date of Birth	
Address:			Phone #
Is this visit the result of an accident?	At work \Box		
	Automobile \square		
DATE OF ACCIDENT:	Т	IME OF ACCIDENT:	
EMPLOYER NAME:		Phone #	
EMPLOYER ADDRESS:			
How did accident / injury occur?			
Body Parts established in WC Case:			
Workers Comp Board Number	Carrie	r Case #	
Address for insurance claims (not the age	ent):		
Insurance Co Address:			
Adjuster's Name & Phone #			
Adjusters Fax #			
Attorney's Name & Phone #:			
PATIENT SIGNATURE:			
PLEASE NOTE THAT FAILURE TO PROVIDE	US WITH THE APPR	OPRIATE CLAIM IN	FORMATION AND OR FAILUR

PLEASE NOTE THAT FAILURE TO PROVIDE US WITH THE APPROPRIATE CLAIM INFORMATION AND OR FAILURE TO FILE A CLAIM WITH YOUR INSURER WILL NECESSITATE US REQUIRING PAYMENT FROM YOU AT THE TIME OF SERVICE.

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NO FAULT INTAKE FORM

I hereby authorize payment directly to WHITE PLAINS HOSPITAL for services rendered relating to an accident/injury covered under NO FAULT insurance benefits.

I hereby authorize the provider of these services to release any medical records relating to my claims to my insurer liable for payment of such claim.

In the event the provider's charges are outstanding and / or fail to file an application for benefits under NO FAULT law, I understand that I am personally responsible for the payment of the charges related to my claim.

Patient's Name		Date of Birth	
Address:		Phone #	
DATE OF ACCIDENT:		_ TIME OF ACCIDENT:	AM / PM
How did accident occur?			
CLAIM #	_ POLICY#_		
Address for insurance claims (not the agent):			
Insurance Co Address:			
Agent's Name & Phone #			
Agent's Fax #			
PATIENT SIGNATURE:		DATE:	

PLEASE NOTE THAT FAILURE TO PROVIDE US WITH THE APPROPRIATE CLAIM INFORMATION AND OR FAILURE TO FILE A CLAIM WITH YOUR INSURER WILL NECESSITATE US REQUIRING PAYMENT FROM YOU AT THE TIME OF SERVICE.