

Workers' Compensation Information

Patient Information	
Patient Name	Account #
Social Security #	WCB Case #
Body Part(s) Injured	Date of Injury
Your Job Title	
Type of Work	
Employer Information	
Employer Name	
Street Address	
City, State, Zip	
Contact Name	Telephone
Workers' Compensation Coverage	
Insurance Company	Claim #
Street Address	
City, State, Zip	
Contact Name	Telephone
Please provide a brief description of how your injury occurred	

***** The above information is required for proper billing of your Workers' Compensation claim. Information not available prior to your first visit should be telephoned in or faxed by the following business day to:**

Canandaigua Orthopaedic Associates, PC
Attention: Workers' Compensation
Telephone (585) 394-3312 Fax (585) 394-8808

Disputed Claims / Failure to Prosecute	
<p>In the event I fail to provide adequate billing information or prosecute a disputed claim, or it is determined by the Workers' Compensation Board that this injury or illness is not the result of a compensable Workers' Compensation case, I hereby agree to pay Canandaigua Orthopaedic Associates their usual and customary fee for services rendered to the above-named patient.</p>	
X	
Patient Signature (parent or guardian if patient is a minor)	Date
Consent to Release Medical Records	
<p>I hereby authorize Canandaigua Orthopaedic Associates to release medical information, including photocopies, to the New York State Workers' Compensation Board, my employer and my employer's Workers' Compensation insurance carrier or other third party payer and its assigns as required for payment as a Workers' Compensation Claim.</p>	
X	
Patient Signature (parent or guardian if patient is a minor)	Date