

**Workers' Compensation Information**

Account # \_\_\_\_\_

Patient Name: \_\_\_\_\_

SS#: \_\_\_\_\_

Body Part Injured: \_\_\_\_\_

Date of Injury : \_\_\_\_\_

WCB Case#: \_\_\_\_\_

Job Title: \_\_\_\_\_

Type of Work: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Workers' Compensation Insurance Carrier Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Claim Number: \_\_\_\_\_

**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)394-0116 Fax: (585)393-9232**

**Disputed Claim / Failure to Prosecute**

*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.*

X \_\_\_\_\_  
Patient Signature (parent or guardian if patient is a minor)

\_\_\_\_\_  
Date

**Consent to Release Medical Records**

*I hereby authorize Canandaigua Orthopaedic Associates to release medical information, including photocopies, to the New York State Workers' Compensation Board and my employer's Workers' Compensation insurance carrier or other third party payer and its assignees as required for payment as a Workers' Compensation Claim.*

X \_\_\_\_\_  
Patient Signature (parent or guardian if patient is a minor)

\_\_\_\_\_  
Date