Riverside Orthopaedic and Sports Medicine ASSOCIATES

5 Columbus Circle
(Broadway betw. 57th & 58th Street)
New York, NY 10019
Tel 212.265.2828 • Fax 212.265.5077

Doctor: _____

WORKERS' COMPENSATION

Was an Automobile involved? _____ Date of injury: ___/___/___

Place of Accident: _____

Are you still working? _____If no, last date worked ___/___/___

Worker's Comp Carrier: _____

Address: _____

City: _____ State: _____ Zip: _____

Claim # _____ Policy # _____

WCB # _____

Workers' Comp. Carrier Phone # _____

Adjuster (Name of person handling your case) _____

Employer at the time of the injury: _____

Address: _____

City: _____ State: _____ Zip: _____

Attorney Name: _____ Phone Number: _____

Attorney Address: _____

City: _____ State: _____ Zip: _____

In the event I fail to prosecure the claim for Workers' Compensation for this illness or condition or it is determined by the Worker's Compensation Board that the illness or condition is not a result of a compensable Workers' Compensation case

I, _____

hereby agree to pay Dr. _____

his usual and customary fees for services rendered.

I HEREBY AUTHORIZE THE DOCTOR TO RELEASE INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO BE RELEASED TO MY COMPENSATION BOARD AND/OR MY ATTORNEY.

Patient's Signature _____ Date: _____

Effective 1/1/13