



NEW MILFORD ORTHOPEDIC ASSOCIATES, P.C.

WORKER'S COMPENSATION

Patient Name _____ Gender: Male _____ Female _____

First Middle Last

Date of Birth ____/____/____ Social Security # ____-____-____ Driver's Lic.# _____

Home Address _____

City _____ State _____ Zip _____

Billing Address (if different) _____

Home Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____

Email Address _____

Marital Status S ___ M ___ D ___ W ___ Occupation _____

Primary Care Physician (PCP) _____ PCP Phone (_____) _____ - _____

Guardian's Name (if a minor) _____ Relationship to Patient _____

Patient's Employer _____ Work Phone (_____) _____ - _____

Employer's Address _____

Spouse's Name _____

Spouse's Employer _____ Spouse's Work Phone (_____) _____ - _____

Spouse's Employer's Address _____

If full-time student indicate school currently attending _____

Emergency Contact _____ Phone (_____) _____ - _____

WORKER'S COMPENSATION INFORMATION ONLY

Worker's Compensation Insurance Carrier: _____

Address of Carrier: _____ Phone (_____) _____ - _____

Contact: _____

CITY STATE ZIP

Date of Injury: ____/____/____ Location: _____

Claim #: _____ WCB Case # _____

How were you injured? _____

Body Part(s) Injured: _____ Date last Worked: ____/____/____

Attorney: _____ Firm Name: _____

Address: _____ Phone (_____) _____ - _____

CITY STATE ZIP

I hereby authorize New Milford Orthopedic Associates, P.C. to release medical information on my injury to the Worker's Compensation Insurance Carrier.

Signed: _____

In the event I fail to prosecute the claim for Worker's 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 Worker's Compensation case, I, _____, hereby agree to pay New Milford Orthopedic Associates, P.C. their usual and customary fees for services rendered to the above named claimant in the above identified case.

Date: _____ **Signed:** _____

PRIMARY INSURANCE CARRIER _____

Policy # _____ Group # _____ Phone (_____) _____ - _____

Address _____

Guarantor's Name _____ Relationship to Patient _____

Guarantor's SS# _____ - _____ - _____ Guarantor's Date of Birth ____/____/____

Employer _____ Employer's Phone (_____) _____ - _____

SECONDARY INSURANCE CARRIER _____

Policy # _____ Group # _____ Phone (_____) _____ - _____

Address _____

Guarantor's Name _____ Relationship to Patient _____

Guarantor's SS# _____ - _____ - _____ Guarantor's Date of Birth ____/____/____

Employer _____ Employer's Phone (_____) _____ - _____

ASSIGNMENT OF BENEFITS: I authorize payemnt of benefits directly to New Milford Orthopedic Associates, P.C. for services rendered. For purposes of payment or audit, I authorize the release of any informaiton acquired in the course of my examination or treatment; I understand that I am financially respnsible to the provider for charges not covered by my benefit plan.

SIGNED: _____ **DATE:** _____

I understand that I am personally responsible to the provider for payment for services rendered.

SIGNED: _____ **DATE:** _____

BILLING INFORMATION ACKNOWLEDGMENT

I, _____, understand and agree that it is my responsibility to be familiar with my medical insurance policy. I agree to provide correct referrals and authorizations. I will pay in full at the time of service if I do not have this information, and I accept responsibility for payment of the entire bill.

Furthermore, I accept and understand that any balances not covered by my insurance(s) are to be paid upon receipt of my bill. If my insurance company has not provided payment, I am responsible for the balance and for contacting the insurance company.

I agree that if my balance due to New Milford Orthopedic Associates, P.C. remains unpaid I will be responsible for interest on the unpaid balance at the rate of 18% per annum, plus cost of collection and reasonable legal fees.

Name Signature Date