WELCOME

PATIENT INFORMATION

DATE: ________________
SS/ID#________________________
PATIENT NAME__________________________________
LAST NAME

______________________________ ________________
FIRST NAME MIDDLE INITIAL

ADDRESS____________________________________
CITY____
STATE_______________ ZIP___________
EMAIL____________________@__________

SEX ☐ M ☐F AGE__________
BIRTHDAY___________________________

☐MARRIED ☐WIDOWED ☐SINGLE ☐MINOR

☐SEPARATED ☐DIVORCED ☐PARTNERED FOR___YEARS

OCCUPATION ______________________________________
PATIENT EMPLOYER/SCHOOL _______________________
EMPLOYER/SCHOOL ADDRESS _______________________
____
EMPLOYER/SCHOOL PHONE _(____)_______-____________
SPOUSE'S NAME ___________________________________
BIRTHDAY____
SS#____
SPOUSE EMPLOYER _________________________________
WHOM MAY WE THANK REFERRING YOU? __________________

INSURANCE

WHO IS RESPONSIBLE FOR THIS ACCOUNT?
____
RELATIONSHIP TO PATIENT _________________________
INSURANCE CO. ________________________________
GROUP #_______________________________________

IS PATIENT COVERED BY ADDITIONAL INSURANCE? ☐Y☐N
SUBSCRIBER'S NAME ____________________________
BIRTHDATE_________SS#_________________________
RELATIONSHIP TO PATIENT _______________________
INSURANCE CO. ________________________________
GROUP # _____________________________________

ASSIGNMENT AND RELEASE

I CERTIFY THAT I, AND/ OR MY DEPENDANT(S) HAVE INSURANCE COVERAGE WITH ___________________________
NAME OF INSURANCE COMPANY

AND ASSIGN DIRECTLY TO **DR. ERIC GOLDBERG** ALL INSURANCE BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE FOR ALL INSURANCE SUBMISSIONS. THE ABOVE-NAMED DOCTOR MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE- NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENTS FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

____
SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

____
PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

____________________ ________________________
DATE RELATIONSHIP TO PATIENT

PHONE NUMBERS

HOME PHONE (_____)__________________________
CELL PHONE (______)_________________________
BEST TIME AND PLACE TO REACH YOU
____
IN CASE OF EMERGENCY, CONTACT

NAME _______________________________________
RELATIONSHIP ________________________________
HOME # (_____)_______________________________
WORK # (_____)_______________________________

ACCIDENT INFORMATION

IS CONDITION DUE TO AN ACCIDENT? ☐YES ☐NO
DATE____________________

TYPE OF ACCIDENT ☐AUTO ☐WORK ☐HOME ☐ OTHER

TO WHOM HAVE YOU MADE A REPORT OF YOUR ACCIDENT?

☐AUTO INSURANCE ☐EMPLOYER ☐WORKERS COMPENSATION

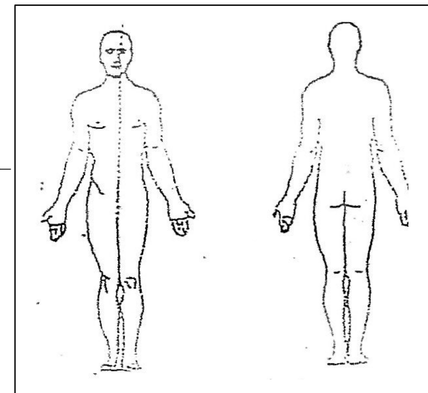
☐ OTHER
ATTORNEY NAME (IF APPLICABLE)

PATIENT CONDITION

REASON FOR VISIT ________________________________ HEIGHT ___________ WEIGHT__________

WHEN DID YOUR SYMPTOMS APPEAR? ___________________________
IS CONDITION GETTING PROGRESSIVELY WORSE? ☐YES ☐NO ☐ UNKNOWN

MARK AN X ON THE PICTURE WHERE YOU CONTINUE TO HAVE PAIN, NUMBNESS, OR TINGLING.



RATE THE SEVERITY OF YOUR PAIN ON A SCALE FROM 1(LEAST PAIN) TO 10 (SEVERE PAIN). ____

TYPE OF PAIN: ☐ SHARP ☐DULL ☐ THROBBING ☐ NUMBNESS ☐ACHING ☐ SHOOTING
☐BURNING ☐ TINGLING ☐ CRAMPS ☐STIFFNESS ☐ SWELLING ☐ OTHER

HOW OFTEN DO YOU HAVE THIS PAIN? ___________________________________

IS IT CONSTANT OR DOES IT COME AND GO? _____________________________

DOES IT INTERFERE WITH YOUR ☐ WORK ☐SLEEP ☐ DAILY ROUTINE ☐RECREATION

ACTIVITIES OR MOVEMENTS THAT ARE PAINFUL TO PERFORM ☐SITTING ☐STANDING ☐ WALKING ☐ BENDING ☐LYING DOWN

HEALTH HISTORY

WHAT TREATMENT HAVE YOU ALREADY RECEIVED FOR YOU CONDITION?

MEDICATIONS SURGERY PHYSICAL THERAPY CHIROPRACTIC SERVICES NONE
OTHER ____

NAME AND ADDRESS OF OTHER DOCTORS WHO HAVE TREATED YOUR CONDITION ______________________

DATE OF LAST: PHYSICAL EXAM ________________ SPINAL X-RAY ______________ BLOOD TEST ___________
SPINAL EXAM __________________ CHEST X-RAY _______________ URINE TEST ____________
DENTAL X-RAY __________________ MRI, CT-SCAN, BONE SCAN _________________________

PLACE A MARK ON "YES" OR "NO" TO INDICATE IF YOU HAVE ONE OF THE FOLLOWING:

AIDS/HIV ☐YES ☐ NO	DIABETES ☐YES ☐ NO	MIGRAINE-HEADACHES . ☐YES ☐ NO	STROKE ☐YES ☐ NO
ALCOHOLISM ☐YES ☐ NO	EMPHYSEMA ☐YES ☐ NO	MISCARRIAGE ☐YES ☐ NO	SUICIDE ATTEMPT ☐YES ☐ NO
ALLERGIES SHOT ☐YES ☐ NO	EPILEPSY ☐YES ☐ NO	MONONUCLEOSIS ☐YES ☐ NO	THYROID PROBLEMS ☐YES☐ NO
ANEMIA ☐YES ☐ NO	FRACTURES ☐YES ☐ NO	MULTIPLE SCLEROSIS ☐YES ☐ NO	TONSILLITIS ☐YES☐ NO
ANOREXIA ☐YES ☐ NO	GLAUCOMA ☐YES ☐ NO	MUMPS ☐YES ☐ NO	TUBERCULOSIS ☐YES ☐ NO
APPENDICITIS ☐YES ☐ NO	GOITER ☐YES ☐ NO	OSTEOPOROSIS ☐YES ☐ NO	TUMORS GROWTH ☐YES ☐ NO
ARTHRITIS ☐YES ☐ NO	GONORRHEA ☐YES ☐ NO	PACEMAKER ☐YES ☐ NO	THYROID FEVER ☐YES ☐ NO
ASTHMA ☐YES ☐ NO	GOUT ☐YES ☐ NO	PARKINSON'S DISEASE ☐YES ☐ NO	ULCERS ☐YES ☐ NO
BLEEDING DISORDERS ☐YES ☐ NO	HEART DISEASE ☐YES ☐ NO	PINCHED NERVE ☐YES ☐ NO	VAGINAL INFECTION ☐YES ☐NO
BREAST LUMP ☐YES ☐ NO	HEPATITIS ☐YES ☐ NO	PNEUMONIA ☐YES ☐ NO	VENEREAL DISEASE ☐YES ☐NO
BRONCHITIS ☐YES ☐ NO	HERNIA ☐YES ☐ NO	POLIO ☐YES ☐ NO	WHOOPING COUGH ☐YES☐ NO
BULIMIA ☐YES ☐ NO	HERNIATED DISK ☐YES ☐ NO	PROSTATE PROBLEM ☐YES ☐ NO	OTHER ______________________________
CANCER ☐YES ☐ NO	HERPES ☐YES ☐ NO	PROSTHESIS ☐YES ☐ NO	
CATARACTS ☐YES ☐ NO	HIGH CHOLESTEROL ☐YES ☐ NO	PSYCHIATRIC CARE ☐YES ☐ NO	
CHEMICAL ☐YES ☐ NO	KIDNEY DISEASE ☐YES ☐ NO	RHEUMATOID ARTHRITIS ☐YES ☐ NO	
DEPENDENCY ☐YES ☐ NO	LIVER DISEASE ☐YES ☐ NO	RHEUMATIC FEVER ☐YES ☐ NO	
CHICKEN POX ☐YES ☐ NO	MEASLES ☐YES ☐ NO	SCARLET FEVER ☐YES☐ NO	

EXERCISE	**WORK ACTIVITY**	**HABITS**	
☐ NONE	☐ SITTING	☐ SMOKING	PACKS A DAY ____________
☐MODERATE	☐ STANDING	☐ALCOHOL	DRINKS/WEEK___________
☐DAILY	☐ LIGHT LABOR	☐COFFEE/CAFFEINE DRINKS	CUPS/DAY _______________
☐HEAVY	☐ HEAVY LABOR	☐HIGH STRESS LEVEL	REASON ________________

ARE YOU PREGNANT? ☐YES ☐ NO DUE DATE__________________________________

INJURIES/SURGERIES YOU HAVE HAD

	DESCRIPTION	**DATE**
FALLS	____	_______________________
HEAD INJURIES	____	_______________________
BROKEN BONES	____	_______________________
DISLOCATIONS	____	_______________________
SURGERIES	____	_______________________

MEDICATIONS	**ALLERGIES**	**VITAMINS/HERBS/MINERALS**
________________________________ ________________________________ PHARMACY NAME ________________ PHARMACY TEL# _________________	________________________________ ________________________________ ________________________________	________________________________ ________________________________ ________________________________

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

NAME ____ BIRTHDAY_________________

SIGNATURE ____

DATE ___________________________

TOTAL MEDICAL N.Y. PC
93-24 QUEENS BLVD. SUITE 1G
REGO PARK, NY, 11374
(T) 718-730-9040 (F) 718-730-9043

ASSIGNMENT AND RELEASE

I CERTIFY THAT I, AND/ OR MY DEPENDANT(S) HAVE INSURANCE COVERAGE WITH

____
NAME OF INSURANCE COMPANY

AND ASSIGN DIRECTLY TO **DR. ERIC GOLDBERG** ALL INSURANCE BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE FOR ALL INSURANCE SUBMISSIONS. THE ABOVE-NAMED DOCTOR MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE- NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENTS FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

____
SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

____
PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

__________________________ ______________________________
DATE RELATIONSHIP TO PATIENT

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. **Please review it carefully.**
Effective: January 1, 2024

Your Rights - You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices - You have choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures - We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, an email to OCRComplaint@hhs.gov, or visiting **https://www.hhs.gov/hipaa/filing-a-complaint/what-to-expect/index.html**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and

share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

To treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for on injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situation such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

For research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services, if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement and other government requests

We can use or share health information about you:

- For workers' compensation claim
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Signature of Patient:_________________________

Print Name of Patient:_________________________ Date:________________

WORKER COMPENSATION INFORMATION

Date: ____________________________

PATIENT INFORMATION

Name ____ Birthday ____

Address ____ Soc. Sec.# ____

____

Telephone ____ Occupation ____

EMPLOYER

Employer Name ____ Employer Tel. ________________________________

Employer Address ____

____ Injury Verified by (for office use):

Contact Person ____ ____

WORKER COMPENSATION CARRIER (FOR OFFICE USE)

Worker Compensation Carrier ____

Carrier Address ____

____

Carrier Phone # ________________________________ Claim # ________________________________

Adjuster's Name ________________________________ Coverage Verified by ________________________________

INJURY INFORMATION

Date of Injury ____________________________ Time ______________ ☐ AM ☐ PM

Place of Injury ____________________________ Accident reported to employer? ☐ Yes ☐ No

Name of person you reported accident to ____

Give full description of how accident happened ____

____

____

____

____

Have you lost time from work? ☐ Yes ☐ No How much? ________________________________

Other doctors seen for this condition:

Doctor's Name ____ Diagnosis ________________________________

Were X-Rays taken? ☐ Yes ☐ No Other tests? ☐ Yes ☐ No

If yes, by whom? Please list test(s), facility(ies) taken and result(s) ________________________________

____

____

Any previous Worker Compensation Injuries ☐ Yes ☐ No Date(s) of previous injuries __________________________

Describe previous Worker Compensation Injuries ____

AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Workers Compensation benefits is denied.

Patient's Signature ____ Date ________________________

PATIENT'S NAME: ________________________________
DATE: ___________________

IS PATIENT DISABLED FROM WORK INJURY?
☐ YES ☐ NO If so, ☐ TOTALLY ☐ PARTIALLY

FIRST DATE OF DISABILITY? _____ / _____ / _____

IS PATIENT CURRENTLY WORKING? ☐ YES ☐ NO

If no, what is the DATE RETURNED? _____ / _____ / _____

IS YOUR RETURN TO WORK: ☐ LIMITED ☐ REGULAR

CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

(Pursuant to Workers' Compensation Law Section 110-a)

PO Box 5205, Binghamton, NY 13902-5205 ● www.wcb.ny.gov

CLAIMANTS ARE PROHIBITED FROM AUTHORIZING RELEASE OF WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT.

PLEASE COMPLETE ALL ITEMS. AN INCOMPLETE FORM WILL DELAY THE PROCESSING OF YOUR REQUEST.

Claimant's Name	Claimant's Social Security or Tax Identification Number	Case Number ☐ WCB ☐ DB ☐ Discrimination ☐ PFL and/or Date of Accident

IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC/PFL CASE NUMBER AND/OR DATE OF ACCIDENT(S)

INSTRUCTIONS:

Submit original to the Workers' Compensation Board and retain a copy for your records. ***Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form.*** **This authorization is effective until it is revoked by the claimant. Claimant may revoke this authorization at any time upon written notice to the Workers' Compensation Board.**

THIS AUTHORIZATION DOES NOT PERMIT YOU TO OPEN AN INDIVIDUAL eCASE ACCOUNT OR TO VIEW CASES VIA eCASE OUTSIDE OF A BOARD LOCATION.

Pursuant to Section 110-a of the Workers' Compensation Law, I, ______________________________,
(CLAIMANT'S NAME)

represent that I am a person who is/was the subject of the workers' compensation cases(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to ______________________________,
(NAME OF A SPECIFIC PERSON, CORPORATION, ASSOCIATION OR PUBLIC OR PRIVATE ENTITY)

at ______________________________.
(ADDRESS)

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

______________________________ ______________
Claimant's Signature (ink only - use blue ink if possible) Date

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)	CLAIM ADMIN CLAIM NUMBER (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	CLAIMANT'S SOC. SEC. NO.

	NAME	ADDRESS APT. NO.
CLAIMANT		
EMPLOYER		
INSURANCE CARRIER		

You may become responsible for the medical costs of treatment for your illness or condition with the health care provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation insurer/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature____ Date ___________________

Provider's Name and Address ____

____

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your health care provider to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or insurer may not be required to pay the provider's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of their bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with their employer or its insurance carrier settling their case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or insurer of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of their bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that they may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the insurer of liability for medical treatment is approved.