ARSENIO MEDICAL, P.C.
NO FAULT AND WORKER'S COMPENSATION INSURANCE

1. All patients must present insurance company's name, full address, telephone number, policy number and claim number, and a contact person from the broker, insurance company or company representative.

2. The billing department of Arsenio Medical, P.C. will bill the no-fault or workers compensation carrier directly. Charges are in accordance with New York State guidelines.

3. No payment is expected with adequate submission of no-fault or workers compensation insurance information, however, it is your responsibility as the patient, to maintain contact with your insurance company to be sure you do not exceed your limits. If your insurance stops or your benefits are denied, you will be responsible for all charges not covered by your no-fault or workers compensation carrier.

4. There may be some cases where a deductible from the insurance carrier must be met. If this applies in your case, you will be responsible to pay the full deductible amount.

5. Should your status change with your case, it is your responsibility to inform this office.

It is our hope that these rules are easily understood and manageable for you. We do not want you to be burdened with necessary medical bills, but at the same time, we need to be paid for our services.

Thank you for reading this outline of insurance information. If we can be of further assistance, please do not hesitate to ask.

X_____
Patient s signature
I have read the above and fully understand.
I have received a copy for my records.

X_____
Witness

_____
Date

Arsenio Medical, P.C.
WORKERS' COMPENSATION Form

Please complete all information below regarding your Workers' Compensation claim. If you are missing any of the requested information needed, please contact us within 24-48 hours so we may file your claim. Failure to contact our office within 24-48 hours will result in you becoming responsible for the balance.

Patient: _____

Social Security#: _____

Date of Birth: _____

Employer: (name, address and phone#)

_____

_____

_____

Date of accident: _____

Address where injury occurred: _____

_____

_____

How injury occurred: _____

_____

_____

Contact at patient's employer: _____ Ph#: _____

Insurance carrier information: (name, address and phone #)

_____

_____

WCB Case #: _____ Carrier Case #: _____

Case Manager:_____ Case Manager Contact Number_____

Billing Address_____

To the best of my knowledge the above information is correct and accurate. I am aware that falsifying this information can lead to me being responsible for any and all charges and I am accepting such responsibility.

Print name: _____ Date: _____

Sign: _____

Information Verified By_____ Date:_____

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)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS	APT. NO.
EMPLOYER			
INSURANCE CARRIER			

You may become responsible for the medical costs of treatment for your illness or condition with the 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 carrier/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 doctor or therapist 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 carrier nay not be required to pay the doctor'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 **~OLI** 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 his/her 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 his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier 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 his/her 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 he/she 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 carrier of liability for medical treatment is approved.