



DR. LAURA E. HARRINGTON
Liverpool Chiropractic & Wellness, PLLC

403 Tulip Street
Liverpool, New York 13088
Telephone: (315) 461-4510

Client Name _____

Date _____

Worker's Compensation Case

Employer Name _____	Work Phone _____
Employer Address _____	City _____ State _____ Zip _____
Insurance Company _____	Insurance Company Phone _____
Ins. Co. Address _____	City _____ State _____ Zip _____
WCB Case # (if known) _____	Carrier Case # (if known) _____
Case Manager Name _____	Phone: _____

Worker's Compensation Information

Date of Accident _____ Time _____ a.m. p.m. Location. (City, Town, or Village) _____

What was your Job Title on the date of accident? _____

Please explain in detail how your accident happened. (Please include location, condition of area, and equipment involved.) _____

Was injury reported to employer? Yes No To whom? _____

Have you seen other doctors for your injury? Yes No

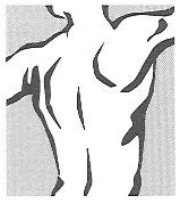
Doctor's name: _____ Doctor's Phone _____

Were X-rays taken? Yes No Other tests? Yes No If yes, please list them and their results _____

Describe that doctor's diagnosis _____

What treatment did you receive _____

Are you still under that doctor's care? _____ If yes, please explain _____



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Worker's Compensation Information (continued)

Have you lost time from work? Yes No How much? _____

Have you returned to work? Yes No If yes, date returned to work _____

Have you ever had a Worker's Compensation claim before? Yes No Please provide us with previous injuries and dates _____

Are your work activities restricted as a result of this accident? Yes No If yes, please explain _____

Do any other diseases or accidents affect your employment? Yes No If yes, please explain _____

Past History

Have you ever been injured in this area before? _____ If yes, when? _____

If injured before, did you lose time from work? _____

If you lost time from work with injuries prior to this injury, give the name and address of doctor(s) consulted _____

Have you been involved in any previous accidents of any kind (personal injury, automobile accident, or worker's compensation)? _____ If yes, please explain details and dates _____

Legal Representation

Have you retained an attorney? Yes No If yes, name, address, and phone # _____

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I authorize release of any information concerning my health care, advice, and treatment provided for the purpose of evaluating and administering claims for Worker's Compensation benefits. I also authorize payments directly to the doctor. In the event that I fail to prosecute the claim for Workers' Compensation for this illness or the condition is not a result of a compensable Workers' Compensation case, I hereby agree to pay the usual and customary fees for services rendered in the above identified care.

X _____ Date _____
 Signature of patient

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 Dr. Laura E. Harrington, DC, 403 Tulip Street, Liverpool, NY 13088

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 may 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 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 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.

State of New York
WORKERS' COMPENSATION BOARD

CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS
 (Pursuant to Workers' Compensation Law Section 110-a)

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

Claimant's Name	Claimant's Social Security No.	Case Number and/or Date of Accident	<input type="checkbox"/> WCB	<input type="checkbox"/> DB	<input type="checkbox"/> Discrimination
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IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC CASE NUMBER AND/OR DATE OF ACCIDENT(S).

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

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 case(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 Dr. Laura E. Harrington, D.C., at _____, Name of a Specific Person, Corporation, Association or Public or Private Entity, 403 Tulip Street, Liverpool, NY 13088. 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) 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.