

**DUE TO FEDERAL HIPPA LAWS WE CANNOT OBTAIN
YOUR WORKERS COMPENSATION INFORMATION**

**YOU MUST PROVIDE THE REQUESTED INFORMATION OR
YOU MAY BE HELD RESPONSIBLE FOR YOUR BILLS**

**AGREEMENT TO PAY MEDICAL COSTS IN THE EVENT OF FAILURE
TO PROSECUTE OR IF COMPENSATION CLAIM IS DISALLOWED**

WCB CASE NO. (if known)	CARRIER CASE NO. (if known)	DATE OF INJURY	BODY PART INJURED	INJURED PERSON'S SOC. SEC. NO.
			<hr/> Circle- Right or Left	
CLAIMANT	NAME:		ADDRESS:	APT. NO:
EMPLOYER				
WORKER'S COMPENSATION INSURANCE				

Describe how and where the injury happened:

In the event I fail to prosecute the claim for workers' compensation for this illness or condition or it is determined by the Workers' Compensation Board that the illness or condition is not a result of a compensable workers' compensation case,

I, _____ hereby agree to pay

Ithaca Orthopaedic Group, PC – located at 10 Brentwood Road Suite B, Ithaca, New York 14850

His/her usual and customary fees for services rendered to the above named claimant in the above identified case.

Date: _____ Signature: _____

If signed by someone other than the claimant, print below the name, address and relationship of the signer.

Name: _____

Address: _____

Relationship: _____