



Grand Island
PHYSICAL THERAPY PC

I _____ request Grand Island Physical Therapy to bill my Physical Therapy treatments under my Workman’s Compensation/No-Fault Insurance. I understand and agree that if for any reason my Workers’ Compensation/No-fault Claims are denied that I am fully responsible for all charges that I have incurred.

I agree to provide Grand Island Physical Therapy with my private insurance information upon my first appointment. If I fail to give Grand Island Physical Therapy all of my necessary insurance information so that they can obtain authorization for treatment, I will be fully responsible for all charges I have incurred.

I also understand that Grand Island Physical Therapy will bill my private insurance only upon denial of payment from my Workers’ Compensation/No-Fault Insurance and that I will be responsible for all of my co-pay charges I incur from my private insurance.

Signed _____

Date _____

Witness _____

Grand Island Office
1801 Grand Island Blvd. Grand Island, NY 14072
(P) 716.773.4323 · (F) 716.773.9418

Kenmore Office
1491 Sheridan Dr., Ste 300 Kenmore, NY 14217
(P) 716.871.1100 · (F) 716.871.1102



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PHYSICAL THERAPY PC

Workers' Compensation Information

Date: _____

Patient Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Date of Birth: _____ Soc. Sec. #: _____

Employer Name and Address: _____

Contact Person in W/C Dept: _____

Date of Accident: _____

Are you seeing a Chiropractor? Yes No

Insurance Carrier Name: _____

Address: _____

Phone: _____

Case Number: _____ WCB Number (W/C only): _____

Referring Doctor: _____

Diagnosis: _____

Length of Treatment (Per Prescription): _____

Date of Prescription: _____

Date called insurance carrier: _____

Spoke with: _____

Treatment authorized thru: _____ Number of approved visits: _____

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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 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.