*CRYSTAL RAY MEDICAL, P.C*
96-14 63RD Drive
Rego Park, NY 11374
Tel (718) 896-0111 Fax (718) 896-2163

# WORKER COMP FORM

**Today's Date:**_____ **Date of Accident:** _____
**Fecha** **Fecha del accidente**

**Name:**_____ **Date of Birth:** _____ **Sex:** ___**M**
**Nombre** **Fecha de naciemiento** ___**F**

**Address:** _____ **Social Security:** _____
**Numero de seguro social**

**Tel: (H)** _____**(W)**_____ **(Cell)** _____**Phone Carrier:**_____

**Name and address of Attorney:** _____
**Nombre y direction de Abogado**

**INSURANCE INFORMATION: INFORMACION DE SEGURO:**

**Name and Address of the Health Insurance:** _____
**Is your name under your insurance: Yes/ No WHO:** _____

**Was this a Work/ Auto injury: If yes Please describe accident:**
**El acidente es relaccionado con el trabajo o carro : describa el acidente**

_____

_____

**Did you go to the Hospital: Fue usted al hospital? NO/YES**_____

_____

**What type of treatment did you receive in the Hospital: Que tratamiento recebio en el hospital?**

_____

_____

**Have you been treated in another office for this condition? Fue tratado por otra oficina para esta condicion: NO/ YES** _____

**What type of medication are you taking: Que medicina esta usando?**_____

_____

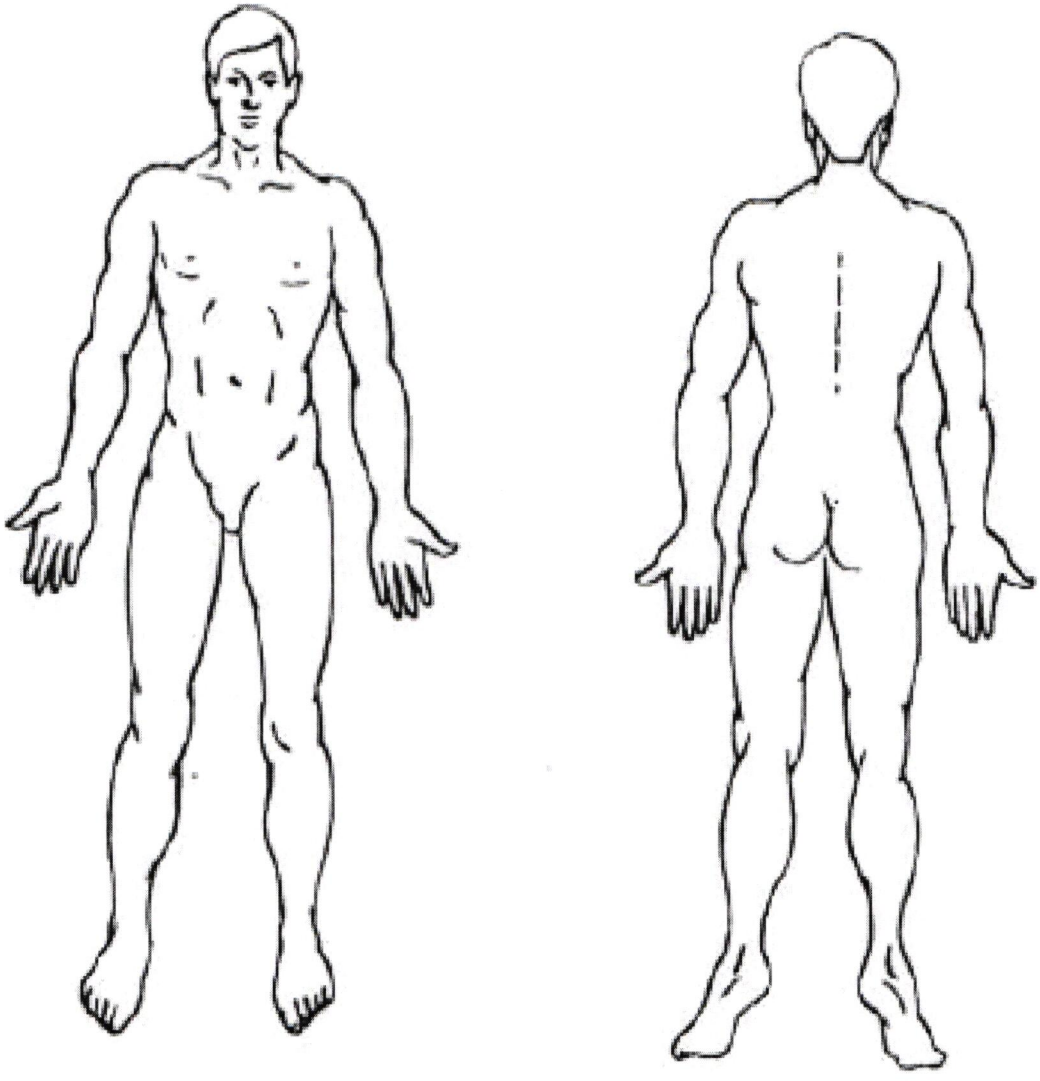
**Have you returned to work since this accident: Ha comensado su trabajo? NO / YES/ PARTIAL date you returned:** _____

**Name and Address of Employment: Nombre y dereccion del trabajo?**

_____ _____

***CRYSTAL RAY MEDICAL, P.C***
**96-14 63RD Drive**
**Rego Park, NY 11374**
**Tel (718) 896-0111 Fax (718) 896-2163**

**PLEASE, PLACE AN X ON THE BODY WERE YOU HAVE PAIN?**



PATIENT SIGNATURE

DATE

*CRYSTAL RAY MEDICAL, P.C*
96-14 63RD Drive
Rego Park, NY 11374
Tel (718) 896-0111 Fax (718) 896-2163

# PATIENT'S RECORDS AND DOCTOR'S LIEN

**To Attorney/Insurance Company:** _____

_____

_____

**Patient's Name:** _____ **Date of Accident/Illness:** ___/___/___

**I do hereby authorize the above provider to furnish you, my attorney/insurance carrier with a full report of his examination, case history, diagnosis, etc. in regards to the accident illness which occurred/began on the above date.**

**I hereby give lien to said doctor on any settlement, judgement, or verdict as a result of said accident/illness and authorized and direct you, my attorney/insurance carrier, to pay directly to said doctor such sum as may be due and owing him for services that are due him, and withhold such sums from any settlement, claim, judgement, or verdict as may be necessary to adequately protect said doctor.**

**I fully understand that I am directly and fully responsible and said doctor for all bills submitted by him for services rendered my and that those agreement is made solely for said doctor's additional protected and in consideration of his awaiting payment. I further understand that such payment is not contingent upon any settlement, claim, judgement, or verdict by which I may eventually recover said fee.**

**Dated:** ____/____/____ **Signature: X** _____
**(Patient)**

**The undersigned, being attorney of record or authorized representative of the insurance company for the above named patient, does hereby acknowledge receipt of the above lien and does agree to honor the same and to withhold sums from any settlement, claim, judgement, or verdict as may be necessary to insure payment of bills received from the above named doctor.**

**Dated:** ____/____/____ **Signature: X** _____
**(Attorney)**

OCA Official Form No.: 960

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

**[This form has been approved by the New York State Department of Health]**

| Patient Name | Date of Birth | Social Security Number |
|---|---|---|
| Patient Address | | |

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test result, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

**Authorization to Discuss Health Information**

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

| 10. Reason for release of information:<br>☐ At request of individual<br>☐ Other: | 11. Date or event on which this authorization will expire: |
|---|---|
| 12. If not the patient, name of person signing form: | 13. Authority to sign on behalf of patient: |

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

NEW YORK STATE | Workers' Compensation Board

# Employee Claim

**C-3**

***State of New York - Workers' Compensation Board***

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

**WCB Case Number (if you know it):** _____

## A. YOUR INFORMATION (Employee)

1. Name: _____ (First / MI / Last) 2. Date of Birth: ____/____/____

3. Mailing address: _____ (Number and Street/PO Box/Apartment No. / City / State / Zip Code)

4. Social Security Number: ___-___-___ 5. Phone Number: (____)_____ 6. Gender: ☐ Male ☐ Female

7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? _____

## B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (____)_____

3. Your work address: _____ (Number and Street / City / State / Zip Code)

4. Date you were hired: ____/____/____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

## C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

## D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ____/____/____ 2. Time of injury: _____ ☐ AM ☐ PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

YOUR NAME: _____ DATE OF INJURY/ILLNESS: ____/____/____
First MI Last

## D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
   If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____
   If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
    If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice given: ____/____/____

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: _____

## E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? ____/____/____ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? ____/____/____ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

## F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? ____/____/____ ☐ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room
   ☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
   Name and address where you were first treated: _____
   _____ Phone Number: (____)_____
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
   Give the name and address of the doctor(s) treating you for this injury/illness: _____
   _____ Phone Number: (____)_____
5. Do you remember having another injury to the same body part or a similar illness? ☐ Yes ☐ No
   If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
   _____
   _____
   _____
6. Was the previous injury/illness work related? ☐ Yes ☐ No
   If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

**I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.**

**Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.**

Employee's Signature: _____ Print Name: _____ Date: ____/____/____

On behalf of Employee: _____ Print Name: _____ Date: ____/____/____

***An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.***

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: ____/____/____

Print Name: _____ Title: _____

ID No., if any: R _____ If Licensed Representative, License No.: _____ Expiration Date: ____/____/____

NEW YORK STATE | Workers' Compensation Board

# Reclamo del empleado

*Estado de Nueva York - Junta de Compensación Obrera*

# C-3

Complete este formulario para solicitar los beneficios de compensación al trabajador por una lesión laboral o una enfermedad relacionada-con el trabajo. Escriba a máquina o en letra de imprenta clara. Este formulario también puede completarse en línea ingresando a www.wcb.ny.gov.

**Número de caso de la WCB (si lo conoce):**_____

## A. SU INFORMACIÓN (empleado)

1. Nombre:_____ (Primer nombre / Inicial 2º nombre / Apellido) 2. Fecha de nacimiento:_____/_____/_____
3. Dirección postal: _____ (Calle y número/Casilla de correo / Ciudad / Estado / Código postal)
4. Número de Seguro Social:_____ 5. Teléfono: (____)_____ 6. Sexo: ☐ Masculino ☐ Femenino
7. Si debe asistir a una audiencia de la Junta, ¿necesitará un traductor? ☐ Sí ☐ No Si responde "Sí", ¿de qué idioma?_____

## B. SU/S EMPLEADOR/ES

1. Empleador al momento de lesionarse:_____ 2. Teléfono:(____)_____
3. Su domicilio laboral:_____ (Calle y número / Ciudad / Estado / Código postal)
4. Fecha de contratación: _____/_____/_____ 5. Nombre de su supervisor:_____
6. Nombres/domicilios de otro/s empleador/es al momento de su lesión/enfermedad:_____

_____

_____

7. ¿Perdió tiempo de trabajo en otro/s empleo/s por la lesión que sufrió o la enfermedad que contrajo? ☐ Sí ☐ No

## C. SU EMPLEO a la fecha de la lesión o enfermedad

1. ¿Cuál era su cargo o cómo describe su tarea?_____
2. ¿Qué tipos de actividades solía realizar? _____

_____

3. Su empleo era... (marque uno) ☐ De tiempo completo ☐ De tiempo parcial ☐ Temporario ☐ Voluntario ☐ Otro: _____
4. ¿Cuál era su remuneración bruta (sin deducir impuestos) por período de pago? _____ 5. ¿Cada cuánto se le pagaba? _____
6. ¿Recibía alojamiento o pagos adicionales a su remuneración? ☐ Sí ☐ No Si responde "Sí", describa: _____

_____

## D. SU LESIÓN O ENFERMEDAD

1. Fecha de la lesión o fecha de la aparición de la enfermedad:_____/_____/_____ 2. Hora en que sufrió la lesión:_____ ☐ A. M. ☐ P. M.
3. ¿Dónde sufrió la lesión/contrajo la enfermedad? (por ej., 1 Main Street, Pottersville, en la entrada principal) _____

_____

4. ¿Este era su lugar de trabajo habitual? ☐ Sí ☐ No Si responde "No", ¿por qué estaba allí?_____

_____

5. ¿Qué estaba haciendo cuando se lesionó o enfermó? (por ej., descargando un camión, preparando un informe)_____

_____

6. ¿Cómo sufrió la lesión/contrajo la enfermedad? (por ej., "tropecé con una tubería y me caí")_____

_____

_____

7. Explique con detalles la naturaleza de su lesión/enfermedad, liste las partes del cuerpo afectadas (por ej., tobillo izquierdo doblado y corte en la frente):

_____

_____

**SU NOMBRE:** _____ **FECHA DE LA LESIÓN/ENFERMEDAD:** _____/_____/_____
Primer nombre Inicial 2º nombre Apellido

## D. SU LESIÓN O ENFERMEDAD *cont.*

8. ¿Hubo algún objeto involucrado en la lesión/enfermedad (por ej., un montacargas, un martillo, ácido)? ☐ Sí ☐ No Si responde "Sí", ¿cuál?_____
9. ¿La herida fue consecuencia del uso o el manejo de un vehículo motorizado con licencia? ☐ Sí ☐ No

   Si responde "Sí", ☐ su vehículo ☐ vehículo de su empleador ☐ otro vehículo ☐ Número de licencia (si lo conoce): _____

   Si estuvo involucrado su vehículo, dé el nombre y domicilio de la aseguradora de su vehículo: _____

   _____
10. ¿Avisó a su empleador (o supervisor) sobre la lesión/enfermedad? ☐ Sí ☐ No

    Si responde "Sí", avisó: _____ ☐ verbalmente ☐ por escrito Fecha de aviso: _____/_____/_____
11. ¿Alguien vio cuando se lesionó? ☐ Sí ☐ No ☐ No lo sé Si responde "Sí", indique quiénes: _____

    _____

## E. REINCORPORACIÓN AL TRABAJO

1. ¿Dejó de trabajar a causa de su lesión/enfermedad? ☐ Sí, ¿en qué fecha? _____/_____/_____ ☐ No, pase a la sección F.
2. ¿Se ha reincorporado al trabajo? ☐ Sí ☐ No Si responde "Sí", ¿en qué fecha? _____/_____/_____ ☐ tarea habitual ☐ tareas limitadas
3. Si se reincorporó al trabajo, ¿para quién trabaja actualmente? ☐ El mismo empleador ☐ Empleador nuevo ☐ Autónomo
4. ¿Cuál es su remuneración bruta (sin deducir impuestos) por período de pago? _____ ¿Cada cuánto se le paga?_____

## F. TRATAMIENTO MÉDICO POR LA LESIÓN O ENFERMEDAD

1. ¿Cuándo recibió su primer tratamiento? _____/_____/_____ ☐ No recibí ninguno (pase a la pregunta F-5)
2. ¿Recibió tratamiento en el lugar? ☐ Sí ☐ No
3. ¿Dónde recibió su primer tratamiento médico externo por su lesión/enfermedad? ☐ No recibí ninguno ☐ Sala de emergencias

   ☐ Consultorio médico ☐ Clínica/Hospital/Atención de urgencia ☐ Internación en hospital más de 24 horas

   Nombre y domicilio del lugar donde lo trataron por primera vez: _____

   _____ Teléfono: (____)_____
4. ¿Se sigue tratando por esta lesión/enfermedad? ☐ Sí ☐ No

   Nombre y domicilio de el/los médico/s que tratan su lesión/enfermedad:_____

   _____ Teléfono: (____)_____
5. ¿Recuerda haber sufrido otra lesión en la misma parte del cuerpo o haber sufrido una enfermedad parecida? ☐ Sí ☐ No

   Si responde "Sí", ¿lo trató un médico? ☐ Sí ☐ No Si responde "Sí", dé los nombres y domicilios de el/los médico/s que lo trataron y **COMPLETE Y PRESENTE EL FORMULARIO C-3.3 JUNTO CON ESTE FORMULARIO:**

   _____

   _____

   _____
6. ¿La lesión/enfermedad anterior se relacionó con el trabajo? ☐ Sí ☐ No

   Si responde "Sí", ¿trabajaba para el mismo empleador que trabaja actualmente? ☐ Sí ☐ No

---

**Por la presente, reclamo los beneficios que establece la Ley de Compensación al Trabajador. Con mi firma certifico que la información que aquí brindo es auténtica y precisa, a mi leal saber y entender.**

**Toda persona que con conocimiento y con la INTENCIÓN DE ESTAFAR presente, o cause que se presente, o prepare información que contenga FALSEDADES u omisiones de hechos concretos sabiendo o creyendo que será presentada a un asegurador o auto asegurador, o que será presentada por éste, SERÁ CULPABLE DE DELITO y estará sujeto a MULTAS Y A LA PRIVACIÓN DE SU LIBERTAD.**

Firma del empleado: _____ Nombre en letra de imprenta:_____ Fecha: ____/____/____

En representación del empleado: _____ Nombre en letra de imprenta:_____ Fecha: ____/____/____

***Un tercero puede firmar en representación del empleado sólo si está autorizado legalmente para hacerlo y el empleado es menor de edad, incapacitado mental o discapacitado.***

Certifico según mi leal saber y entender, después de indagaciones razonables bajo las circunstancias del caso, que las declaraciones y otras cuestiones prácticas asentadas más arriba cuentan con evidencia que las respalda, o pueden ser respaldadas por evidencias si se realizan investigaciones o existen hallazgos posteriores.

Firma del abogado/representante (si corresponde): _____ Fecha: ____/____/____

Nombre en letra de imprenta: _____ Cargo: _____

N.º de ID, si aplica: **R** _____ Si es un representante autorizado, N.° de licencia: _____ Fecha de vencimiento: ____/____/____

# 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.

## ADVIERTA QUE USTED PUEDE LLEGAR A SER RESPONSABLE POR LOS COSTOS MÉDICOS EN CASO DE ABANDONO DEL PROCESO, O SI SE RECHAZA LA SOLICITUD DE INDEMNIZACIÓN, O SI SE APRUEBA UN ACUERDO EN VIRTUD DE LA LEY DE INDEMNIZACIÓN LABORAL WCL §32

| Nº DE CASO WCB (si se conoce) | Nº. DE CASO DE LA ASEGURADORA (si se conoce) | FECHA DE LA LESIÓN | NATURALEZA DE LA LESIÓN O ENFERMEDAD | Nº SEG. SOC. DE PERSONAS LESIONADAS |
|---|---|---|---|---|
| | | | | |
| RECLAMANTE | NOMBRE | | DIRECCIÓN | APT. NO. |
| EMPLEADOR | | | | |
| COMPAÑÍA DE SEGUROS | | | | |

Usted puede llegar a ser responsable por hacer el pago de los costos médicos del tratamiento de su enfermedad o condición al proveedor que se indica a continuación si (1) abandona el proceso de compensación laboral (2) si la institución Workers' Compensation Board (Junta de Compensación Laboral) determina que la enfermedad o condición que requería tratamiento no ocurrió por un accidente de trabajo indemnizable o enfermedad ocupacional o (3) si el acuerdo fue tramitado por usted y aprobado conforme a la Ley de Indemnización de Trabajadores WCL §32 ; en virtud de esta ley, usted renuncia a sus derechos de obtener los beneficios médicos de la compañía aseguradora de indemnizaciones laborales o del empleador auto asegurado para cubrir los tratamientos y servicios realizados después de la fecha en que se aprobó el acuerdo. Si ocurriera cualquiera de los hechos mencionados con anterioridad, el proveedor podrá cobrarle directamente el costo por los servicios recibidos en lugar de hacerlo al empleador o a la compañía aseguradora, y usted será responsable por hacer los pagos correspondientes.

Por medio de la presente reconozco que he leído el párrafo anterior y que entiendo las circunstancias bajo las cuales me hago responsable del pago.

Firma del reclamante _____ Fecha _____

Nombre y dirección del proveedor _____

**AL RECLAMANTE**

La Regulación 325-1.23 de la institución Workers' Compensation Board (Junta de Compensación Laboral) permite que su doctor o terapeuta le solicite que firme esta notificación A-9. Al firmar esta notificación, usted reconoce la obligación de pagar los honorarios al proveedor por los servicios que recibe en el supuesto caso que la ley no requiera que su empleador o aseguradora de indemnización laboral pague tales honorarios y si tales honorarios no están cubiertos por otro seguro. Es posible que el empleador o aseguradora no deba pagar los honorarios médicos si, por ejemplo, usted no presenta una solicitud de indemnización laboral, o si no notifica su lesión o enfermedad a su empleador, o si no asiste a la audiencia de la institución Workers' Compensation Board si su empleador desafía sus derechos a los beneficios. Aun cuando hubiese realizado todos los trámites necesarios para procesar su solicitud, la institución Workers' Compensation Board puede decidir que usted no tiene derecho a los beneficios. En tal caso, esta notificación le aconseja a su proveedor de servicios de salud que usted reconozca su responsabilidad personal por el pago de sus cuentas.

**Artículo 32 de la Ley de Indemnización Laboral (WCL 32)**

La notificación A-9 también cubre las instancias en las que un reclamante por un caso de compensación laboral válido existente llega a un acuerdo con su empleador/a o su compañía aseguradora tras resolver su caso según el artículo 32 de la ley WCL. Un acuerdo según el Artículo 32 puede incluir una cláusula que libere al empleador/a o aseguradora de la responsabilidad de pagar en el futuro cuentas médicas asociadas con el caso. Su proveedor de servicios médicos puede solicitar que usted firme esta notificación A-9 para garantizar que reconoce su responsabilidad personal por el pago de sus cuentas si renunció al derecho de recibir beneficios médicos futuros mediante un acuerdo conforme al artículo 32.

Si tiene alguna pregunta, comuníquese con su abogado o representante autorizado para la audiencia, de tener uno. También puede comunicarse con la institución Workers' Compensation Board (Junta de Compensación Laboral) en la oficina de su distrito.

**AL PROVEEDOR DE SERVICIOS DE SALUD**

Esta notificación tiene el fin de avisar al reclamante de indemnización laboral que puede ser responsable del pago. Si el reclamante no firma este formulario, no libera con este acto al proveedor de su obligación de tratar al reclamante, ni tampoco anula la responsabilidad de pago por parte del reclamante.

Mantenga el original de este formulario en sus propios registros y entregue una copia al reclamante. **No lo presente en la institución Workers Compensation Board** (Junta de Compensación Laboral). Usted recibirá notificaciones de las decisiones en las que se incluirá si la solicitud es indemnizable, la autorización del tratamiento o el pago de cuentas médicas. También se le notificará si el reclamante presenta un acuerdo conforme al Artículo 32 para que lo apruebe la institución Workers' Compensation Board. No cobre al reclamante a menos que y hasta que usted reciba una decisión de la institución Workers Compensation Board que indique: 1) que el reclamante no procesará la solicitud, o 2) que la solicitud fue rechazada, o 3) que el tratamiento no tiene relación causal con las lesiones laborales, o 4) que se aprobó un acuerdo conforme al Artículo 32 liberando a la aseguradora de la responsabilidad por el tratamiento médico.

NEW YORK STATE | Workers' Compensation Board

# 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.