

Suffolk Plastic Surgeons, P.C.
179 Belle Meade Road, Suite 1 E. Setauket, NY 11733 (631)751-4400

WORKERS COMPENSATION INFORMATION

Employer _____ Position _____
Address: _____ City _____ State _____ Zip _____
Phone#: _____ Date of injury _____
Place of injury(City): _____ Comp Carrier _____
Comp carrier Polc#: _____ Comp Carrier Address: _____
WCB#: _____
Carrier Case#: _____ Have you lost time from work? _____
Has employer reported injury to the Workers Compensation Board? _____
Describe how injury occurred: _____

I agree to pay the usual and customary fees for services rendered in the event I fail to prosecute the claim for Worker's Compensation or if the compensation claim is disallowed.

Signature _____ Date _____

NO-FAULT INFORMATION

Insurance Company _____ Phone#: _____
Address _____ City _____ State _____ Zip _____
Policy Holder _____ Insurance Representative _____
Policy#: _____ File# _____
Date of Accident _____ Patient's Age _____

I hereby authorize direct payment of **No-Fault** benefits to the above named Physican, not to exceed the balance due of the Physician's allowable charges under ARTICLE 18 of the No-Fault Law for services rendered. I understand that I am financially responsible for the above.

Signature _____ Date _____