□ 1900 Ridge Road, West Seneca, NY 14224 Tel: 716.712.0670 Fax: 716.712.0674
□ 2075 Sheridan Drive, Kenmore, NY 14223 Tel: 716.447.6474 Fax: 716.447.6433

HealthWorks-WNY-LLP: Consent for Treatment for an On-The-Job Injury

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____ SS#: _____

Local Address: _____ City: _____ State: _____ Zip Code: _____

Local Phone: _____ Date of Birth: _____ Gender: _____

Emergency Contact: _____ Phone No.: _____ Primary Physician: _____

Employer Information:

Employer: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____ Occupation: _____

Please describe how the injury occurred and which body parts are involved: _____

_____

_____

_____

Date and time of present injury: _____ Date injury was reported to Employer: _____

Complete Name & Title of person injury was reported to: _____

Was there a prior injury to the same body part? ❒Yes ❒No When was prior injury? _____ Healed completely? ❒Yes ❒No

Who treated prior injury? (Doctor's name and location) _____

I authorize HealthWorks-WNY, LLP, through its physicians and other health providers, to examine, diagnose and offer treatment for the condition I present with today. In the event I fail to prosecute the claim for Worker's Compensation for this injury or condition, or if it is determined that this injury or condition is NOT related to my employment at the above stated employer and my employer does not pay for my evaluation & treatment, I agree to pay HealthWorks-WNY, LLP for all the charges incurred as a result of this and any subsequent visits related to this.

I assign all rights to payments for these services from employers or insurance carriers to HealthWorks-WNY, LLP. I authorize the release of any medical records associated with this or subsequent visits as may be needed to prosecute this claim through the Worker's Compensation System.

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 this form.

Signature of Claimant: _____ Date: _____ Time: _____

Parent/Guardian Signature
(If patient is a minor): _____ Relationship: _____

REFUSAL OF CARE WAIVER -Do not complete unless requested.

I understand that I am leaving HealthWorks-WNY, LLP against the advice of the physician. I am refusing the recommended treatment for the condition diagnosed today.

Patient Signature: _____ Date: _____ Time: _____

Witnessed by: _____ Date: _____ Time: _____