SPECIALTY ORTHOPAEDICS, PLLC

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

ARE YOU CURRENTLY WORKING? YES / NO

WBC CASE NO.	**CARRIER CASE NO.**	**DATE OF INJURY**	**NATURE OF INJURY**

CLAIMANT		**ADDRESS**
EMPLOYER		**ADDRESS**
INSURANCE CARRIER		**ADDRESS**
CLAIM ADJUSTER		**PHONE:** **FAX:**

IN THE EVENT THAT 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 *SPECIALTY ORTHOPAEDICS, PLLC* LOCATED AT 600 MAMARONECK AVENUE, SUITE 101, HARRISON, NY 10528, THE USUAL AND CUSTOMARY FEES FOR SERVICES RENDERED TO THE ABOVE NAMED CLAIMANT IN THE ABOVE IDENTIFIED CASE.

DATE:_____ SIGNATURE:_____

IF SIGNED BY OTHER THAN CLAIMANT, PRINT BELOW: NAME, ADDRESS AND RELATIONSHIP TO CLAIMANT

NAME & ADDRESS_____

RELATIONSHIP TO CLAIMANT_____

TO BE COMPLETED BY THE PHYSICIAN

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? Yes ____ No____

2. Are the patient's complaints consistent with his/her history of the injury/illness? Yes ____ No ____

3. Is the patient's history of the injury/illness consistent with your objective findings? Yes ____ No ____

4. What is the percentage (0-100%) of temporary impairment? _____%