

WELCOME TO THE OFFICE OF
STUART B. CHERNEY, M.D., P.C.
PRACTICE LIMITED TO ORTHOPAEDIC SURGERY

290 E. MAIN STREET, SUITE 700
SMITHTOWN, NEW YORK 11787
(631)361-7867

Today's Date: _____

Referred By: _____

WORKER'S COMPENSATION

PATIENT NAME: _____

AGE: _____ BIRTHDATE: _____ SS#: _____

HOME ADDRESS: _____

CITY/TOWN: _____ STATE: _____ ZIP: _____

PHONE #: _____ CELL PHONE#: _____

PRESENT COMPLAINT: _____

PATIENT'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

CITY/TOWN: _____

STATE: _____ ZIP: _____ PHONE # _____

COMPENSATION INSURANCE COMPANY NAME: _____

ADDRESS: _____

CITY/TOWN: _____

STATE: _____ ZIP: _____ PHONE #: _____

DATE OF INJURY: _____ LAST DATE WORKED : _____

CARRIER CASE#: _____

BRIEFLY STATE HOW INJURY OCCURRED: _____

PRIVATE INSURANCE CO: _____

ADDRESS: _____

CITY/TOWN: _____

STATE: _____ ZIP: _____ PHONE #: _____

INSURED PARTY: _____ INSURED BIRTHDATE: _____

SS#: _____ POLICY #: _____ ID#: _____

PLEASE READ : ALL CHARGES ARE DUE AT THE TIME OF SERVICE. IF SURGERY IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE CLAIM FORMS TO THE OFFICE PRIOR TO SURGERY. ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE STUART B. CHERNEY, M.D. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

SIGNATURE: _____ DATE: _____

