TIER ORTHOPEDIC ASSOCIATES, PC
240 RIVERSIDE DRIVE
JOHNSON CITY, NY 13790
607-798-9356

To correctly bill and supply your WC (workman's compensation) or NF (no-fault) insurance with the correct information we will need the following information from you. Please provide this information to our office within 48 hours of your visit.

**You may also fax this form to 607-770-6887**

Patient Name: _____DOB:_____

Employer Name: _____
(at time of the injury)

Address: _____

Date of Injury: _____ Job Title: _____

Body Part/Area injured:_____

Brief Description of how the injury occurred: _____

_____

WC or NF Insurance Carrier: _____

Address: _____

Claim#_____WCB#_____

Adjuster's Name (if known)_____

Are you currently working? YES or NO

Have you filed a claim with your employer? YES or NO (if workman's compensation)

It is your responsibility to get this information to us immediately so that we can bill for your services, if you do not return this information and/or it is deemed that this is not a work related or No-Fault injury, you or your private ins. will be responsible for any balance at our office.

Patient Signature: _____

Date: _____