WESTERN NEW YORK UROLOGY ASSOCIATES, LLC
Workers' Compensation Information

Name _____ Date _____

Employer _____

Compensation Insurance Carrier_____

Address _____ Phone _____

Workers' Compensation Case Number _____ Date of Injury _____

How were you hurt? _____

_____

Referring Physician _____

WORKERS' COMPENSATION PAYMENT AGREEMENT

I _____, _____,
(First Name) (Last Name)

understand that I am responsible for payment in full of any charges related to my care at Western New York Urology Associates, LLC, should my claim for Workers' Compensation for this injury/illness/condition stated above be denied by my employer's medical insurance carrier or Workers' Compensation Board of New York State.

Patient's signature_____ Date _____