State of New York
WORKERS' COMPENSATION BOARD

Notice of Right to Select a Workers' Compensation Board Authorized Health Care Provider

Injured Employee's Name	Injured Employee's Social Security No.	Date of Accident
Employer's Name and Address		

To the Injured Employee:
For the treatment of your work-related injury or illness, you may choose any physician, podiatrist, chiropractor, or psychologist (upon referral from an authorized physician) who is Workers' Compensation Board authorized and who is accepting workers' compensation patients.

While you may choose to utilize a network or provider which is recommended by your employer or its workers' compensation insurance carrier or to permit your employer to select a provider on your behalf, you may, at any time, change your health care provider without jeopardizing your workers' compensation claim for benefits.

Signature of Injured Employee _____ Date _____ Signature of Witness _____ Date _____

Please note: It is not necessary for you to sign this consent form if your employer is (i) participating in a certified preferred provider organization (PPO) under Article 10-A of the Workers' Compensation Law, or (ii) participating in the alternative dispute resolution (ADR) pilot program under section 25(2-c) of the Workers' Compensation Law. In accordance with these statutory programs, except in emergency situations, you must obtain at least initial treatment for any workers' compensation injury or illness from the certified network(s) or providers designated by your employer.

To the Employer:
The employer shall provide the above-named injured employee with a copy of this signed form and shall maintain the original form in the employer's records where it may be inspected by the Workers' Compensation Board at any time. This form shall not be submitted to the Workers' Compensation Board nor shall it be executed prior to the occurrence of this employee's work-related injury or illness.

The Workers' Compensation Board employs and serves people with disabilities without discrimination.

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS	APT. NO.
EMPLOYER			
INSURANCE CARRIER			

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/ services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature_____ Date _____

Provider's Name and Address _____

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.

WORKERS' COMPENSATION BOARD

CENTRALIZED MAILING, PO Box 5205, Binghamton, NY 13902-5205

State of New York
WORKERS' COMPENSATION BOARD

CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

(Pursuant to Workers' Compensation Law Section 110-a)

PLEASE COMPLETE ALL ITEMS. AN INCOMPLETE FORM WILL DELAY THE PROCESSING OF YOUR REQUEST.

Claimant's Name	Claimant's Social Security No.	Case Number ☐WCB ☐DB ☐Discrimination and/or Date of Accident

IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC CASE NUMBER AND/OR DATE OF ACCIDENT(S).

CLAIMANT IS PROHIBITED FROM AUTHORIZING RELEASE OF WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT.

INSTRUCTIONS:

Submit original to the Workers' Compensation Board and retain a copy for your records. *Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form.* This authorization is effective until it is revoked by the claimant. Claimant may revoke this authorization at any time upon written notice to the Workers' Compensation Board.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO OPEN AN INDIVIDUAL eCASE ACCOUNT OR TO VIEW CASES VIA eCASE OUTSIDE OF A BOARD LOCATION.

Pursuant to Section 110-a of the Workers' Compensation Law, I, _____,
Claimant's Name
represent that I am a person who is/was the subject of the Workers' Compensation case(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to

_____, at
Name of a Specific Person, Corporation, Association or Public or Private Entity

_____.
Address

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

_____ _____
Claimant's Signature (ink only -- use blue ballpoint pen if possible) Date

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.

Pursuant to Workers' Compensation Law Section 110-a:

3. Individual authorization. Notwithstanding the restrictions on disclosure set forth under subdivision one of this section, a person who is the subject of a workers' compensation record may authorize the release, re-release or publication of his or her record to a specific person not otherwise authorized to receive such record, by submitting written authorization for such release to the board on a form prescribed by the chair or by a notarized original authorization specifically directing the board to release workers' compensation records to such person. However, in accordance with section one hundred twenty-five of this article, no such authorization directing disclosure of records to a prospective employer shall be valid; nor shall an authorization permitting disclosure of records in connection with assessing fitness or capability for employment be valid, and no disclosure of records shall be made pursuant thereto. It shall be unlawful for any person to consider for the purpose of assessing eligibility for a benefit, or as the basis for an employment-related action, an individual's failure to provide authorization under this subdivision.

4. It shall be unlawful for any person who has obtained copies of board records or individually identifiable information from board records to disclose such information to any person who is not otherwise lawfully entitled to obtain these records.

5. Any person who knowingly and willfully obtains workers' compensation records which contain individually identifiable information under false pretenses or otherwise violates this section shall be guilty of a class A misdemeanor and shall be subject upon conviction, to a fine of not more than one thousand dollars.

6. In addition to or in lieu of any criminal proceeding available under this section, whenever there shall be a violation of this section, application may be made by the attorney general in the name of the people of the state of New York to a court or justice having jurisdiction by a special proceeding to issue an injunction, and upon notice to the defendant of not less than five days, to enjoin and restrain the continuance of such violations; and if it shall appear to the satisfaction of the court or justice that the defendant has, in fact, violated this section, an injunction may be issued by such court or justice, enjoining and restraining any further violation, without requiring proof that any person has, in fact, been injured or damaged thereby. In any such proceeding, the court may make allowances to the attorney general as provided in paragraph six of subdivision (a) of section eighty-three hundred three of the civil practice law and rules, and direct restitution. Whenever the court shall determine that a violation of this section has occurred, the court may impose a civil penalty of not more than five hundred dollars for the first violation, and not more than one thousand dollars for the second or subsequent violation within a three year period. In connection with any such proposed application, the attorney general is authorized to take proof and make a determination of the relevant facts and to issue subpoenas in accordance with the civil practice law and rules.

ASSIGNMENT, LIEN, AUTHORIZATION AND SIGNATURE

* _____ * _____

Patient's Name **Insured's Name**

* _____ * _____

Insurance Company **Claim Number**

I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to ***Nassau Open MRI, P.C.*** such sums as may be due and owing ***Nassau Open MRI, P.C.*** for services rendered me or my family members, both by reason of accident or illness, and by reason of any other bills that are due ***Nassau Open MRI, P.C.*** and to withhold such sums from any disability benefits obligated to reimburse me or from any settlement judgment or verdict on my behalf as may be necessary to adequately protect ***Nassau Open MRI, P.C.*** This document is to act as an assignment of my rights and benefits to the extent of the services provided by ***Nassau Open MRI, P.C.*** In the event that a direct assignment of my rights and benefits are not permitted or accepted, this assignment shall be considered a direct assignment of any proceeds or payments to be paid to me.

I hereby sign and give a lien to ***Nassau Open MRI, P.C.*** against any and all insurance benefits named herein and any and all proceeds of settlement judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated.

In the event that my insurance company, which is obligated to make payments to me, ***Nassau Open MRI, P.C.*** upon the charges made by ***Nassau Open MRI, P.C.*** refuses to make such payments either upon the demand of ***Nassau Open MRI, P.C.*** or me. I hereby assign and transfer to ***Nassau Open MRI, P.C.*** any and all causes of action that I might have or that might exist in my favor against such insurance company and authorized ***Nassau Open, P.C.***to prosecute said cause(s) of action either in my name or in name. I further authorize ***Nassau Open, P.C.***to compromise, settle, or otherwise resolve said claim(s) or cause(s) of action as they see fit.

I understand that I remain personally responsible for the total amounts due to the medical provider for any and all services rendered me by ***Nassau Open MRI, P.C.*** I understand and agree that if my Workmen's Compensation or No-Fault or Lien or Private Insurance claim is denied because I failed to comply with the conditions set forth by those agencies (i.e., returning paperwork, body part not accepted, appearing for hearings, EUO's, etc.), or my medical bills exceed the applicable limit, then I accept responsibility for the full balance due for any and all services rendered me or my family members. I further understand and agree that this assignment does not constitute any consideration for ***Nassau Open MRI, P.C.*** to await payments that ***Nassau Open MRI, P.C.*** as its option, may demand from me immediately upon rendering services.

I hereby authorize ***Nassau Open MRI, P.C.*** to release any information pertinent to my case to any insurance company or attorney to facilitate collection under this assignment. I agree that ***Nassau Open MRI, P.C.*** be given special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment of my bills.

This document shall stand as my signature on file.

This assignment is to become effective as of the day indicated below and shall remain effective as long as services are being rendered to me/or my family members and/or until all Third Party monies owed to ***Nassau Open MRI, P.C.*** for services rendered are paid in full.

A photocopy of this assignment shall be considered as effective and valid as the original.

I attest that the terms of the assignment have been satisfactorily explained to me by the staff at ***Nassau Open MRI, P.C.*** prior to signing this document. I further attest that I have read and understand the Notice of Alternative Treatment posed at the bottom of this document.

* _____ * _____

Patient's Signature **Date**

Notice of Alternative Treatment

Our patients are advised that they have the option of seeking treatment at the office/facility of another ***Nassau Open MRI, P.C.*** *not affiliated with* ***Nassau Open MRI, P.C.***. Our patients may have any procedure, test or treatment recommended by any doctor in this office performed in the office/facility of another medical provider. A listing of alternative health care services and/or ***Nassau Open MRI, P.C.*** may be found in the classified section of the telephone directory under appropriate heading or upon the patient's request; the staff of ***Nassau Open MRI, P.C.*** will do their best to provide information about other medical providers where appropriate and/or similar services may be obtained.

Nassau Open MRI, P.C.

TEL: 718-815-2002 FAX: 718-815-3003

Patient Information Sheet

** All Requested Information **MUST** be Completed **

Patient's Name:
Nombre del paciente:
Last: _____ **Middle:** _____ **First:** _____

Patient Maiden Name: (if applicable) _____
Apellido de soltera del paciente:

Patient's Address: _____ ***Apt #:*** _____
Dirección del paciente: El apartamento

_____

Patient's Telephone: _____ **Cell Phone:** _____
Numero de teléfono Telefono Celular

Date of Birth: _____ **Date of Accident:** _____
Fecha de nacimiento: Fecha de accidente:

Insurance Company: _____
Compañía de seguro:

Policy & Claim Number: _____
Numero de poliza:

Referring Doctors Name: _____
Doctor que lo refirió:

Referring Doctor's Tel: _____
Telefono del doctor:

Social Security # _____
Numero de Seguro Social

***Attorney's Name*:** _____
Nombre del abogado:

Attorney's Tel*:** _____ ***Attorney's Fax: _____
Teléfono del abogado: Numero de facsimile:

**** Favor de completar toda la información requerida ****

Nassau Open MRI, P.C.

PATIENT'S INTERVIEW SCREENING FORM

Your doctor has scheduled you for a Magnetic Resonance Imaging (MRI) scan. The machine looks like a CT scanner and utilizes a magnetic field and radio frequency waves to obtain images. There are no known biohazards.

MRI forms pictures of the body by positioning it within a magnetic field. Radio signals are transmitted into the tissues and a computer records the "echos" which return. The pattern of the echos is made into a picture of the body's internal structures. Because of the presence of a magnetic field, it is important we are aware of any metallic objects that may have been surgically implanted into your body. Therefore, an accurate surgical and medical history is needed. Also, magnetically attracted objects worn must be removed before entering the MRI exam suite.

We would like to know if you have any of the items listed below. Please check the appropriate responses.

YES	NO	
___	___	Cardiac Pacemaker
___	___	Neurostimulator (TENS unit)
___	___	Other implanted electrodes, pumps or electronic devices
___	___	Diabetic Insulin Pump
___	___	Brain Aneurysm Clip (History of brain surgery)
___	___	Shunt
___	___	Seizures
___	___	heart Bypass Surgery
___	___	Heart Valve Surgery
___	___	Cardiac Arrhythmias
___	___	Other Heart Surgeries
___	___	Abdominal Aneurysm Clip
___	___	Other Abdominal Surgeries
___	___	Eye Prosthesis
___	___	Hearing Aid
___	___	Dentures
___	___	Middle Ear Prosthesis
___	___	Metal Mesh
___	___	Wire Sutures
___	___	War Injury or Gunshot Wound
___	___	Other known possible metal fragments in the head, eye or body (Ex: welders, machinists, sheet metal workers, etc.)
___	___	IUD
___	___	Penile Prosthesis
___	___	Joint/Limb Replacement
___	___	Fractured bones treated with metal rods, metal plates, pins, screws, nails or clips
___	___	Harrington Rods
___	___	Prosthesis (Ex: artificial limbs)
___	___	Permanent Eye Liner
___	___	Wig, Toupee, etc.
___	___	Makeup with Metallic Fragments
___	___	Known or Possible Pregnancy
___	___	Nervousness in confined spaces (Claustrophobia)
___	___	Other: _____

I have read the above information and answered the preceding questions to the best of my knowledge. I hereby give my consent to have a Magnetic Resonance Image Scan. Any questions I may have had were directed to my doctor or the MRI staff.

Patient Name _____ **Patient Signature** _____ **Date** _____

Body Part _____ **Date of Birth** _____ **Referring Doctor** _____ **WC NF LIEN Pvt.**

Nassau Open MRI, P.C.

P.O. Box 30272
Mariners Harbor, New York 10303-0272
Tel 718-815-2002 Fax 718-815-3003

PREGNANCY DENIAL FORM

TO ALL WOMAN OF CHILD BEARING AGE (AGES 12 AND UP):

PLEASE READ THE STATEMENT BELOW. IF TRUE, PLEASE SIGN AND DATE. THANK YOU.

To Whom It May Concern:

I, _____, hereby state that there is no possibility that I am pregnant at this time.

_____
SIGNATURE

_____
DATE

Nassau Open MRI, P.C.

P.O. Box 30272
Mariners Harbor, New York 10303-0272
Tel 718-815-2002 Fax 718-815-3003

Video Surveillance Policy–Patient Acknowledgement, Consent and Release

Please be informed this entire property, located at Nassau Open MRI, P.C., (the "Property"), is under ***video surveillance 24 hours a day***. For security purposes ***you are being recorded*** from the time you enter the Property until the time you leave the property.

Video surveillance systems are in use throughout the property, including, but not limited to, the waiting room, reception, elevators, hallways, MRI Room, X-Ray Room and all general common spaces. The video surveillance system ***is not*** in use in areas where there is a reasonable expectation of privacy to disrobe, such as a restroom, dressing area or locker room. This is a non-cloud based surveillance system. The video surveillance system is recorded in the administrative offices of the Practice. The DVR is located on-site and is rewritten every 30 days.

The ***primary purpose*** of the Video Surveillance system is to allow for the after-the-fact-investigation or crimes committed against Nassau Open MRI, P.C. (the "Practice"). In addition, the video surveillance system, including video recordings, may be used and stored as required by the Practice, in its sole discretion including, but not limited to, for the purpose of assisting in the investigation of certain types of safety violations, as a tool of patient supervision, employee diligence, and/or documentation. However, the Practice shall only use and store recorded videos in compliance with the Health Insurance Portability and Accountability Act and the Health Information Technology for Economic and Clinical Health Act.

I hereby give my consent to the video surveillance, including the storage and use of video recordings, as the Practice deems fit in its sole discretion.

_____ _____ _____