



Klemmt Orthopaedic Services

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WORKERS COMPENSATION/ NO FAULT INFORMATION AND PATIENT AGREEMENT

Worker's Comp. /No Fault Carrier _____ Injury/ Illness Date _____

Policy #/Claim # _____

WCB # _____

CC # _____

Phone # (_____) _____ - _____

Case Manager _____

Is this injury work related? ___ Yes ___ No

Is this injury No Fault: ___ Yes ___ No

If Workers Comp:

Employer _____ Work Phone # (_____) _____ - _____

Employer Address _____

All Workers Compensation Patients:

We cannot provide any device or fulfill any prescription without written prior authorization from your Worker's Compensation Insurance provider. Please be advised this is beyond our control and may prolong your orthotic or prosthetic services.

We will contact you when we have received approval to schedule delivery.

Patient Signature _____ Date _____

No Fault Patients please see back of form →