



HEARTLAND MEDICAL SERVICES, P.C.  
251 RICHMOND HILL ROAD  
STATEN ISLAND, NEW YORK 10314

Lawrence F. Wasser, M.D.

**INFORMATION FOR COMPENSATION CASE PATIENTS**

We will not ask you for payment if your treatment is for a compensable injury received on the job. We must, however, have your employer's name and address and the name of insurance company so that we can bill them. Please understand that if your employer's insurance company does not consider your injury compensable, **WE MUST BILL YOU DIRECTLY.**

Since MEDICAL CARE is being rendered to you (the patient), it is your responsibility to notify your employer of your injury and to obtain all necessary information and **GIVE US THE CASE NUMBER** when known.

Employer's name in full: \_\_\_\_\_

Address In Full (including zip code) \_\_\_\_\_

Phone Number & Supervisor \_\_\_\_\_

Compensation Insurance Carriers name, address and policy number given by Employer for Workers Compensation Board \_\_\_\_\_

Patient's Social Security Number \_\_\_\_\_

Patient's Signature \_\_\_\_\_

I.D. given to Receptionist \_\_\_\_\_

HEARTLAND MEDICAL  
WORKERS' COMPENSATION  
TAX ID # 13-3207383  
251 Richmond Hill Road  
Staten Island, New York 10314

Part I (to be filled out by receptionist)

Patient's Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Date Stamp: \_\_\_\_\_

\*\*\*\*\*

Part II (to be filled out by physician)

Diagnosis: \_\_\_\_\_

Work Status: Check one:

Return to Work - Full Duty \_\_\_\_\_

**Limited Duty Only** (for example:

can answer phone, no lifting) \_\_\_\_\_

No driving \_\_\_\_\_

No lifting \_\_\_\_\_

No prolonged standing \_\_\_\_\_

No use of \_\_\_\_\_ hand \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SEARS, COSTCO, VISY, HOME  
DEPOT, & TARGET:**

Limited duty status applies to all  
injured employees unless seriously  
disabled (including patients referred  
to specialists).

**UPS:** All limited duty employees  
must be rechecked in 3 days.

\_\_\_\_\_ # of days limited duty

Other

\_\_\_\_\_

\_\_\_\_\_

Heartland Medical Follow-up date (if any) \_\_\_\_\_

Referral to specialist physician (if any) \_\_\_\_\_

**FRONT DESK: TURN THIS FORM IN IMMEDIATELY TO VIVIAN ROMANO**

\_\_\_\_\_  
Physician's signature

HEARTLAND MEDICAL SERVICES, P.C.  
WORKERS' COMPENSATION - INITIAL VISIT

Today's Date: \_\_\_\_\_ Date of Accident: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Temp: \_\_\_\_\_

Physician's Evaluation: Chief Complaint (history of present illness or injury)

Past Medical History:

Personal & Occupational History:

Review of Systems:

Physical Exam: H.E.E.N.T.:

Neck:

Resp:

Abd:

Extem:

Neuro/spine

Diagnostic Impression:

**WORKERS' COMPENSATION/NO FAULT PATIENTS**

**YOUR CARRIER CASE #  
OR  
CLAIM #  
IS REQUIRED  
BY THIS OFFICE WITHIN 10 BUSINESS DAYS.**

**PLEASE CALL VIVIAN AT (718) 761-2800  
BETWEEN 9AM – 5 PM  
OR  
YOU MAY LEAVE A MESSAGE WITH A RECEPTIONIST  
ANY OTHER TIME  
WITH YOUR NAME AND CASE #.**

**\*\* WITHOUT THIS NUMBER YOU WILL BE HELD  
RESPONSIBLE FOR ALL CHARGES  
DENIED BY THE INSURANCE COMPANY DUE TO NO  
RECORD OF AN INJURY**