ORTHOPAEDIC ASSOCIATES OF CENTRAL TEXAS
Ph. 512-244-0766 • Fax 512-244-1013
www.oactdocs.com

AUSTIN BONE & JOINT CLINIC
Phone 512-477-6341 · Fax 512-477-1148
www.abjortho.com

GAO GREATER AUSTIN ORTHOPAEDICS
Phone 512-401-8400 · Fax 512-441-6388
www.gaortho.com

WORKERS' COMPENSATION DISCLOSURE

Jay M. Borick, MD
Marco E. Bosquez, MD
M. Tyrrell Burrus, MD
Dean Chen, MD
Jeffrey G. DeLoach, DO
Josh C. Fox, MD
David O. Gillory III, MD
Robert D. Graham, MD
Newt Hasson, MD
Charles J. Hubbard, DPM
J. Taylor Jobe, MD
Gordon Marshall, MD
Mark S. Parrella, MD
John C. Pearce, MD
Stephen M. Pearce, MD
Michael E. Putney, MD
Stephen Rose, MD
Mustasim N. Rumi, MD
Eugene P. Schoch, MD
Benjamin Szerlip, DO
Michael S. Valastro, MD
Galen S. Wachtman, MD
Steve C. Wilson, MD

DISCLOSURE

To provide efficient quality service to the patient, we require that you carefully review and sign the following agreement.

(Pursuant to TWCC Rule 120.1 FIGURE 1 & 120.2)
If you are seeking care at our facilities for an injury/condition due to work, please note that we are required by the Texas Workers' Compensation Commission laws to handle your claim with your employer's Workers' Compensation Insurance Carrier.

After you have reviewed the provided information, please check the most applicable statement.

☐ I certify that my injury/condition ***IS*** work related.

Should your injury become fully adjudicated not to be compensable as defined by the Division of Worker's Compensation or the insurance carrier is relieved of liability under §408.024 of the Texas Workers' Compensation Act, or your claim is denied, you will assume all financial responsibility for the billing of your injury/condition; at which time, you may provide your private health insurance information.

☐ I certify that my injury/condition ***IS NOT*** work related.

AGREEMENT

As a patient of Orthopaedic Associates of Central Texas/Austin Bone & Joint Clinic, with a work related injury/condition, it is your responsibility to inform this facility immediately of the following:

1. **You must provide this facility with your employers information:**
   - Name of the company
   - Name of the contact person
   - Phone number

2. **You must provide this facility with your employer's Workers' Compensation Insurance Carrier information:**
   - Name of Workers' Compensation Insurance Carrier
   - Name of contact person
   - Claim#
   - Phone number

3. **You must inform this facility if you have had any of the following:**
   - Designated doctor evaluation
   - Required medical evaluation
   - Impairment ratings

4. **You must immediately notify this facility if your claim is disputed, denied or if you receive a Notice of Refusal to Pay Benefits, more commonly referred to as a dWC 021 and/or PLN-11.**

Failure to disclose any of the above information in a timely manner may cause you (the patient) to become financially responsible for all services rendered. Should you have questions regarding this disclosure, please ask to speak to a Worker's Compensation Representative.

ACKNOWLEDGEMENT

Patient Name _____

Patient Signature _____ Date _____

ORTHOPAEDIC ASSOCIATES
OF CENTRAL TEXAS

North Austin - OACT
12309 N. Mopac Expy.
Suite 150
Austin, TX 78758

Round Rock - OACT
16020 Park Valley Dr.
Round Rock, TX 78681

Cedar Park - OACT
1401 Medical Parkway
Building C, Suite 100
Cedar Park, TX 78613

Forest Creek - OACT
4112 Links Lane
Suite 101
Round Rock, TX 78664

GAO
GREATER AUSTIN
ORTHOPAEDICS

Lockhart - GAO
1009 San Antonio St.
Lockhart, TX 78644

South Austin - GAO
5625 Eiger Rd.
Suite 175
Austin, TX 78735

James Casey St. - GAO
4310 James Casey St.
Suite 3-C
Austin, TX 78745

AUSTIN
BONE &
JOINT
CLINIC

South Austin - ABJ
5625 Eiger Rd.
Suite 175
Austin, TX 78735

Austin - ABJ
1015 East 32nd Street
Suite 101
Austin, TX 78705

LaGrange - ABJ
657 E. Travis Street
Suite C
LaGrange, TX 78945