BUFFALO SPINE SURGERY

Center For Excellence in Spine Care Dr. Andrew Cappuccino

WCB # _____ Carrier Case # _____

Date of Injury _____ SS # _____

NAME ADDRESS

CLAIMANT _____

EMPLOYER _____

INSURANCE CARRIER _____

In the event that I fail to prosecute the claim for Workman's Compensation for this illness or condition, or if it is determined by the Workman's Compensation Board that the illness or condition is not as a result of a compensable Workman's Compensation case, I _____ hereby agree to pay Buffalo Spine Surgery, PLLC their usual and customary fees for services rendered for the above named claimant in the above identified case.

Signature _____

Printed Name _____

Relationship to Claimant _____

Address _____