VSAS Orthopaedics
www.vsas.com

1250 S. Cedar Crest Blvd., Suite 110, Allentown, PA 18103 610-435-1003 *fax* 610-435-3184
2649 Schoenersville Rd., Suite 101, Bethlehem, PA 18017 610-317-3440 *fax* 610-317-3443
Satellite Office 333 Normal Ave., Kutztown, PA 19530-1640

Specialty Care for All Ages

Barry I. Berger, M.D.
Pediatric Orthopaedics
General Orthopaedics
Trauma & Fracture Care

Mitchell E. Cooper, M.D.
Sports Medicine
Arthroscopic Surgery
General Orthopaedics

Thomas D. DiBenedetto, M.D.
General Orthopaedics

Amir H. Fayyazi, M.D.
Orthopaedic Spine Surgeon

Dale J. Federico, M.D.
Sports Medicine
Arthroscopic Surgery

Joshua S. Krassen, D.O.
Physiatry & Spine Care
EMG/Electrodiagnosis
Epidural Injections

Eric B. Lebby, M.D.
Arthritic Joint Reconstruction
Hip & Knee Replacement

Neal A. Stansbury, M.D.
Sports Medicine
Arthroscopic Surgery
General Orthopaedics
CAQ Sports Medicine

John J. Stapleton, D.P.M.
Podiatry, Foot & Ankle Surgery

Prody A. Ververeli, M.D.
Arthritic Joint Reconstruction
Hip & Knee Replacement

Mark Walter, D.C.
Certified Chiropractic Physician

Lawrence E. Weiss, M.D.
Hand, Wrist & Elbow Surgery
CAQ Hand Surgery

George A. Arangio, M.D.
Emeritus

David B. Sussman, M.D.
Emeritus

Andrew T. Prokurat
Chief Operating Officer

Computerized Radiology
Dexa Scan
Open MRI - Whole Body
Ultrasound

Hand Therapy
Physical Therapy

Fracture & Sports Injury Center
Joint Replacement Center

FINANCIAL LIABILITY AGREEMENT
WORKER'S COMPENSATION

I, _____ have been advised that should my Worker's Compensation carrier deny my claim my health insurance carrier will be billed for all services. If I do not have health insurance I will be responsible for all balances.

- ❑ I have supplied my Worker's Compensation and Health Insurance information Valley Sports and Arthritis Surgeons. I agree to be financially responsible for any unpaid/denied services by either carrier.

- ❑ I will not supply my Health Insurance information to Valley Sports and Arthritis Surgeons or have no health insurance and agree to be financially responsible for all services denied by my Worker's Compensation carrier. I will sign a Payment Consent form with my credit card information for Valley Sports and Arthritis Surgeons to bill my credit card for any outstanding balances.

- ❑ I do not have Health Insurance and I agree to be financially responsible for all Services denied by my Worker's Compensation Carrier. I will sign a Payment Consent form with my credit card information for Valley Sports and Arthritis Surgeons to bill my credit card for any outstanding balances.

I understand that I will be billed in accordance with the Worker's Compensation Regulations of Pennsylvania.

_____ _____
Signature Date

WORKERS' COMPENSATION
ENROLLMENT FORM

Date: _____

Patient Name: _____ DOB: _____

Name of Employer: _____

Employer Address: _____

_____

Telephone Number: _____ Contact: _____

County of Employer: _____

Date of Injury: _____ Body Area Injured: _____

Workers' Compensation Insurance Information:

Insurance Carrier Name: _____

Insurance Carrier Address: _____

_____

Claim Number: _____

Insurance Phone #: _____ Adjuster: _____

The above information is required for proper billing to your insurance carrier. Failure to provide this information to Valley Sports and Arthritis Surgeons may result in you being financially responsible for any and all services.