

Employee Claim

State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

WCB Case Number (If you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____ 2. Date of Birth: ____/____/____
First MI Last

3. Mailing address: _____
Number and Street/PO Box City State Zip Code

4. Social Security Number: _____ 5. Phone Number: (____) _____ 6. Gender: Male Female

7. Will you need a translator if you have to attend a Board hearing? Yes No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (____) _____

3. Your work address: _____
Number and Street City State Zip Code

4. Date you were hired: ____/____/____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? Yes No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) Full Time Part Time Seasonal Volunteer Other: _____

4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? Yes No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ____/____/____ 2. Time of injury: _____ AM PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

4. Was this your usual work location? Yes No If no, why were you at this location? _____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

Worker's Compensation Questionnaire

Name of claimant _____

Date of Injury ____/____/____ Time of Injury ____:____ am/pm

Name of employer at time of incident _____

Employer's address _____

Employer's phone# _____ Supervisor's name _____

Occupation/job title _____

Was there an accident report filed? Yes No

Do you have a copy? Yes No

If yes please provide us with a copy

Do you have an attorney? Yes No Do you need an attorney? Yes No

Attorney's name _____

Attorney's address _____

Attorney's phone # _____ Fax# _____

Name of carrier _____

Carrier's phone # _____ Adjustor _____

Carrier case# _____ WCB# _____

Social security # _____ Were you driving at the time? Yes No

Please give us a brief description of the incident

*In the event that I fail to prosecute the claim for workers compensation for this injury or condition or it is determined by the WCB that the injury is not a result of a compensable case, I _____, hereby agree to pay South Shore Chiropractic, PC located at 700 Horseblock Rd, Farmingville, NY 11738, for services rendered in the treatment regarding the above identified incident.

Signature X _____ Date _____

HEALTH QUESTIONNAIRE

PLEASE CHECK ALL THAT APPLY:

MUSCULO SKELETAL SYSTEM

- Low back problems
- Pain between shoulders
- Neck problems
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Rupture
- Broken bones

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on breast
- Are you pregnant?
- Yes No

GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting food
- Vomiting blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

CARDIO VASCULAR RESPIRATORY SYSTEM

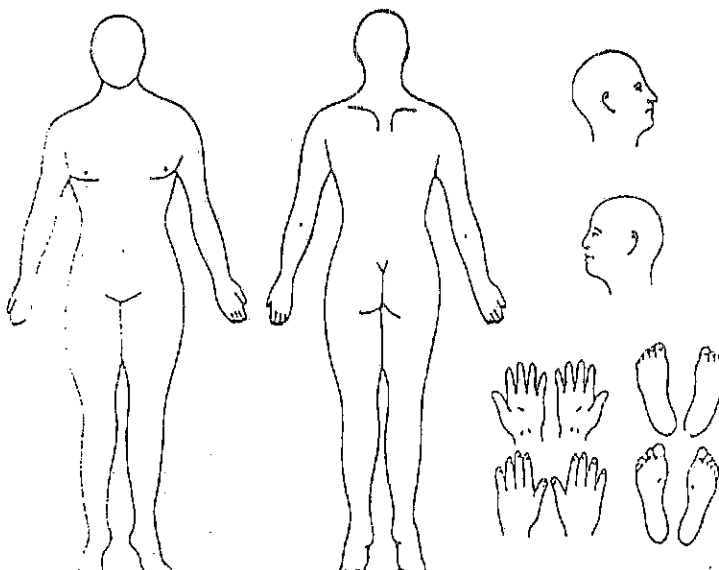
- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

EYES, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Hearing loss
- Ear discharge
- Nose pain
- Nose bleeding
- Nose discharge
- Difficulty breathing thru nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech

NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression



Patient's Signature

*****DO NOT WRITE BELOW THIS LINE*****

Patient Accepted? Yes No Doctor's Signature _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

(1) I hereby authorize (name of provider) _____

(2) To discuss the following information from the health records of:

Patient name: _____ Date of birth: _____

Address: _____ Telephone: _____

_____ Medical Record Number: _____

Dates of Service: _____

(3) Information to be disclosed:

- (A) complete health record(s) discharge summary billing records
 history & physical progress notes
 x-ray reports laboratory tests
 other (please specify) _____

(B) I understand that this will include information relating to (check if applicable): (If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law.)

- acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
 behavioral health services/psychiatric care
 treatment for alcohol and/or drug abuse
 domestic abuse

Initials: _____

(4) At the request of the patient, this information is to be released to: South Shore Chiropractic
700 Horseblock Road
Farmingville, NY 11738
for the purpose of: _____
Fax # (631) 732-1544

(5) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 12 months from the date signed. I understand that signing this authorization is voluntary. I also understand I may refuse to sign this form and that my health care and payment will not be affected.

Date: _____ Initials: _____

(6) The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for the above disclosure of the above information to the extent indicated and authorized herein.

(7) I may request a copy of this form after signing.

(8) Information disclosed under this authorization might be re-disclosed by the recipient (except as noted in 3 B) and this re-disclosure may no longer be protected by federal or state law.

Initials: _____

Signed: _____
(patient) (this form to be completed before signing) (date)

(legal representative) (relationship to patient -- description of authority) (date)

(signature of witness) (relationship to patient) (date)

Note: Release of all confidential information is governed by State and Federal and HIPAA Regulations.
06/04/04

WCB Case No. (if you know it): _____

To Claimant: If you received treatment for a *previous* injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your previous injury/illness to your employer's workers' compensation insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) says you have a right to get a copy of this form. If you do not understand this form, talk to your legal representative. If you do not have a legal representative, the Advocate for Injured Workers at the Workers' Compensation Board can help you. Call: 800-580-6665.

To Health Care Provider: A copy of this HIPAA-compliant release allows you to disclose health information. If you send records to the employer's workers' compensation insurer in response to this release, also mail copies to the Claimant's legal representative. (If no legal representative is listed below, send copies to the Claimant.) Health care providers who release records must follow New York state law and HIPAA.

This release is:

- **Voluntary.** Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- **Limited.** It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- **Temporary.** It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- **Revocable.** You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's workers' compensation insurer and the Workers' Compensation Board. *Note: You may not cancel this release with respect to medical records already provided.*
- **For records only.** It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's workers' compensation insurer.

This form does NOT allow your health care provider(s) to release the following types of information:

- **HIV-related information**
- **Psychotherapy notes**
- **Alcohol/Drug treatment**
- **Mental Health treatment** (unless you check below)
- **Verbal information** (your health care providers may not discuss your health care information with anyone)

Any medical records released will become part of your workers' compensation file and are confidential under the Workers' Compensation Law.

A. YOUR INFORMATION (Claimant)

1. Name: _____ 2. Social Security Number: _____ - _____ - _____
3. Mailing Address: _____
4. Date of Birth: ____/____/____ 5. Date of the current injury/illness: ____/____/____
6. Current injury/illness, including all body parts injured: _____
7. Your legal representative's name and address (if any): _____

Check here if you allow your health care provider(s) to release **mental health care** information.

B. YOUR HEALTH CARE PROVIDER(S) (List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers attach their contact information to this form.)

1. Provider: _____ 2. Phone Number: (____) _____
3. Mailing Address: _____
4. Other provider (if any): _____ 5. Phone Number: (____) _____
6. Mailing Address: _____

C. READ AND SIGN BELOW. I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

Claimant's signature (ink only -- use blue ballpoint pen, if possible.) _____ Date _____

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below:

Your name _____ Relationship to Claimant _____ Signature (ink only -- use blue ballpoint pen, if possible.) _____ Date _____

South Shore Chiropractic, P.C.

700 Horseblock Rd.
Farmingville, NY 11738
Telephone: (631) 732 - 1386

450 William Floyd Parkway
Shirley, NY 11967
Telephone: (631) 395 - 8520

Fax: (631) 732 - 1544
sschiropractic@optonline.net

Chiropractic Informed Consent To Treat

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and/or other tests on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working, or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, falls, dizziness, headaches, burns with modalities and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Dr. Michael J. Campo

Dr. Jayesh Patel

Dr. Marc Avvento

Patient Signature (or patient representative)

Date

(indicate relationship if signing for patient) _____

South Shore Chiropractic, P.C.

700 Horseblock Rd.
Farmingville, NY 11738
Telephone: (631) 732 - 1386
Fax: (631) 732 - 1544

450 William Floyd Parkway
Shirley, NY 11967
Telephone: (631) 395 - 8520
Fax: (631) 395 - 8521

sschiropractic@optonline.net

Patient: _____
Employer: _____
Claim Group: _____
SS# / ID#: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

South Shore Chiropractic, P.C.
700 Horseblock Rd.
Farmingville, NY 11738

OR

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

South Shore Chiropractic, P.C.
700 Horseblock Rd.
Farmingville, NY 11738

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at South Shore Chiropractic, P.C. this _____ day of _____, 20____
(Date) (Month)

Signature of Policyholder

Witness

Signature of Claimant, if other than Policyholder