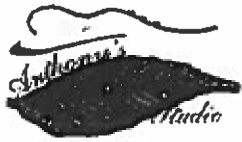


Patient Intake Form

General Information

Patient name ______________________________ Sex M__ F__ DOB___/___/ ______

Address ______________________________ City______________ State________ Zip ________

Phone(Home)__________________ Cell & cell carrier __________________ Work__________

Email Address ____

Emergency Contact ____ Phone___________

Address ____Relationship ________

Employment (circle) Full Time Part Time Retired Not Employed Student

Employer ________________________________ Employer Phone # ________________

Insurance provider___________________________ Insurance ID # _________________

Who referred you today? ____

___ Friend/Family member ___Promo ___Internet ___Phonebook ___Other

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Atlas Chiropractic of Syracuse, P.L.L.C. will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Atlas Chiropractic of Syracuse, P.L.L.C. will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. If I choose to suspend or terminate my care at this office, any outstanding charges for professional services rendered to me are immediately due and payable. I agree that I am responsible for all attorney and legal fees if legal action becomes necessary to collect this account. I authorize Atlas Chiropractic of Syracuse, P.L.L.C. to obtain a credit report if deemed necessary.

I understand and am informed that, as in all other healthcare offices, in the practice of chiropractic, there are some risks to treatment, including but not limited to muscle strains and sprains, fractures, dislocation, disc injuries, and strokes. I understand that I cannot expect the doctors to anticipate all risks and complications that may result from treatment. I wish to rely on the doctors to exercise judgment during the course of the treatment, which they feel at the time, based upon the facts known, and are in my best interest.

I have read, or have had read to me, the above consent and release, and have had the opportunity to ask questions about its content.

Patient signature ____ Date ________

Guardian signature authorizing care ________________________________ Date ________

Please check all that apply:

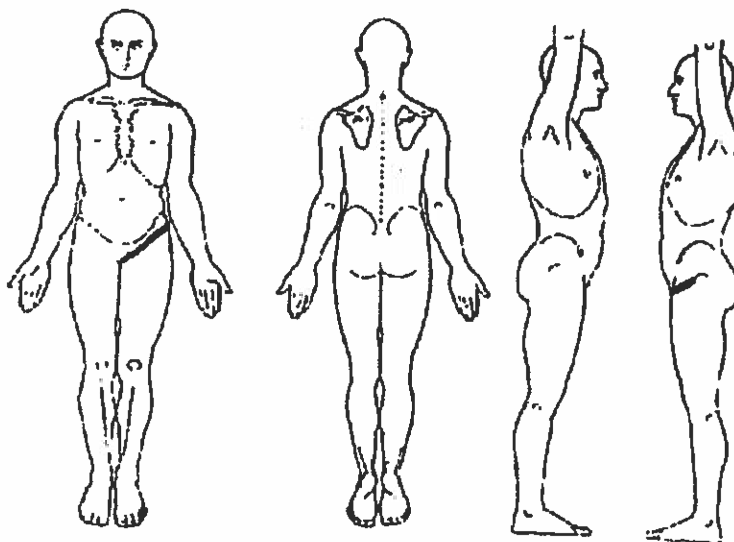
__ Fractured Bones
__ Auto Accidents
__0-1 Years Ago
__ 1-5 Years Ago
__ Over 5 Years Ago
__ Other Accidents/Falls
__ Arthritis
__ Diabetes
__ Convulsions, epilepsy
__ Skin Problems
__ Cancer
__ Frequent Colds, Flu
__ Depressed
__ Irritable
__ Anemia
__ Allergies, Sinus
__ Under extreme stress
__ Eating disorders
__ Trouble Sleeping
__ Trouble concentrating
__ Learning Disability
__ Mood Changes

__ Neck Pain or Stiffness R L
__ Numbness, tingling, or Pain in arms, hands, or Fingers R L
__ Jaw Pain or Click (TMJ) R L
__ Difficulty in excessive Twisting, standing, sitting, Riding, bending, or lifting
__ Shoulder Pain R L
__ Dizziness
__ Ringing in ears R L
__ Hearing Loss
__ Blurred or Double Vision
__ Upper back pain, stiffness
__ Mid back pain, stiffness
__ Lower back pain, stiffness
__ Pain with cough, sneeze
__ Hip pain R L
__ Headaches

__ Numbness, tingling, pain In buttocks, legs, feet, toes R L
__ Foot trouble R L
__ Chest pain, asthma
__ Heart problems
__ Stroke
__ High/Low blood pressure
__ Varicose Veins
__ Liver trouble
__ Gall bladder trouble
__ Digestive problems
__ Ulcers
__ Hemorrhoids
__ Prostate problems
__ Impotence
__ Kidney trouble
__ Menstrual Problems PMS
__ Pregnant (now)
__ Bedwetting
__ Ear Infections
__ AIDS,HIV

Please mark the area of injury or discomfort on the diagram below using the appropriate symbols.

Numbness: - - - - - - - -
Aching: XXXXXXXXX
Burning: ^^^^^^^^
Pins & Needles: o o o o o o
Stabbing: ɷɷɷɷɷ



Initial visit

PCP: Karoly Toth D.C.

Complaint: 1.____________ 2____________ 3____________

Is the injury accident related? _____Motor Vehicle/ _____ Work accident/ If yes, when?____________

Date of onset (of complaint): 1. ____________2. ____________3. ____________

Location (of complaint): 1.____________2. ____________3. ____________

Neurological (numbness/tingling in extremities) (circle) yes no
Location (of numbness and/or tingling) 1. ____________2. ____________3. ____________

Radiation/Referral (of pain to other parts of the body): (circle) yes no
location(of radiating pain): 1. ____________2. ____________3. ____________

Quality (sharp, shooting, dull etc. of complaint) 1. ____________2. ____________3.____________

Timing/Frequency (how long and how frequent of complaint):
1. ____________2.____________3. ____________

Palliative (what makes the complaint better): 1.____________2. ____________3. ____________
Provocative (what aggravates the complaint): 1. ____________2. ____________3. ____________

Review of Systems: Is documented in the chart on the new patient intake sheet dated today's date. It was reviewed with patient and felt to be non-contributory, and if applicable-with the exception of

Past Medical History: ____________

Past Surgical History: ____________

Current medications:____________

Allergies: ____________

Social History:
Psych ( ) Patient is awake, alert and oriented to person, place and time. Patient affect is appropriate to the situation. They are good/poor historian requiring little/moderate/ considerable prompting
( ) Abnormal: (specify) ____________

Smoker: ( )yes ( ) no Details: ____________
ETOH/Substance: ____________ MVA/Trauma: ____________

ANTHONY'S BODYWORKS STUDIO
ATLAS CHIROPRACTIC OF SYRACUSE P.L.L.C.
141 SHOP CITY PLAZA
SYRACUSE, N.Y. 13206

Phone: (315) 414-0224

Fax: (315) 414-0396

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

We are required by applicable federal and state law to maintain the privacy of your protected health information (PHI). We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect June 1, 2007 and will remain in effect until we replace it.

Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Understanding what is in your medical record and how your health information is used helps you to better understand who, what, when, where and why others may access your health information and make better informed decisions when authorizing disclosures to others.

HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED:

Treatment: Atlas Chiropractic of Syracuse P.L.L.C. may use and disclose your health information to a physician or other healthcare providers who are involved in taking care of you. For example, we may disclose information to other facilities when scheduling other medical appointments, setting up an MRI, X-rays, etc...

Payment: Atlas Chiropractic of Syracuse P.L.L.C. may disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: In order for Atlas Chiropractic of Syracuse P.L.L.C. to operate in accordance with applicable law and insurance requirements and in order for the practice to continue to provide quality and efficient care, it may be necessary for us to compile, use and/or disclose you PHI in order to evaluate the performance of our personnel in providing care to you.

Appointment Reminders: Atlas Chiropractic of Syracuse P.L.L.C. may contact you to remind you that you have an appointment or need a referral for an appointment. This may be left on your answering machine, voice mail, postcard, etc., unless you inform us otherwise.

Your Authorization: In addition to our use of your health information for treatment, payment of healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may also revoke it in writing at any time. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Family/Friends: Atlas Chiropractic of Syracuse P.L.L.C may disclose your health information to your family member, other relative or a close personal friend, or any other person identified by you, but only if you agree that we may do so.

Individuals Involved In Your Care Or Payment For Your Care: Atlas Chiropractic of Syracuse P.L.L.C. may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care, but only if you agree that we may do so. We will only disclose the health information directly relevant to their involvement in your care.

Marketing: Atlas Chiropractic of Syracuse P.L.L.C. will not use and/or disclose your health information for marketing activities without your written authorization.

Required By Law: Atlas Chiropractic of Syracuse P.L.L.C. may use or disclose your health information, when required by federal,

state, or local law.

Neglect Or Domestic Abuse: Atlas Chiropractic of Syracuse P.L.L.C. may disclose your health information to appropriate authorities, if we reasonable believe that you are a possible victim of abuse, neglect or domestic abuse, without *Workers Compensations*: Atlas Chiropractic of Syracuse P.L.L.C. may disclose your health information as authorized to comply with worker's compensation laws.

Law Enforcement: Atlas Chiropractic of Syracuse P.L.L.C. may release your protected health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons of similar process subject to all applicable legal requirements.

YOUR HEALTH INFORMATION RIGHTS

You Have The Right To Inspect And Maintain A Copy Of Your Protected Health Information: You may inspect and maintain a copy of your medical and billing records. A reasonable copying charge may apply.

You Have the Right to Request Restriction of Your Health Information: You may ask us to restrict or limit disclosure of your health information; however, we are not required to agree to these restrictions. If the chiropractor believes it is in your best interest to permit use and disclosure of you information, it will not be restricted. If the chiropractor does agree to these restrictions, we will abide by our agreement (except in an emergency).

You Have The Right To Request To Receive Confidential Communications From Us By Alternative Means Or At An Alternative Location: You may make this request in writing to our practice's privacy officer and your request must specify the alternate means of location you request.

You Have The Right To Receive An Accounting Of Disclosures Of Your Health Information: You have the right to receive a list of instances in which Atlas Chiropractic of Syracuse P.L.L.C. disclosed your health information other than treatment, payment or healthcare operation or for disclosures that occurred prior to June 1, 2007. You must submit a written request to the contact officer and must include a time frame, which may not be longer than seven years or may not include dates prior to June 1, 2007.

You Have The Right To Request That We Amend Your Health Information: To request an amendment, you must submit your request in writing to our practice's privacy officer and provide a reason that supports your request. Atlas Chiropractic of Syracuse P.L.L.C. may deny your request under certain circumstances.

You Have the Right To Register A Complaint If You Feel Your Privacy Rights Have Been Violated: If you believe your privacy rights have been violated you may file a complaint with our practice's privacy officer. You must also file a complaint with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

We reserve the right to change our privacy practices and applicable law permits the terms of his notice at any time. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Atlas Chiropractic of Syracuse P.L.L.C.
141 Shop City Plaza, Syracuse, NY 13206

Phone: (315) 414-0224
Fax: (315) 414- 0396

____ I acknowledge that I have read and understand this privacy notice. ____ I would like a copy of this privacy notice

____
Print Name

____
Patient's Signature Date

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ______________________ **Date** __________

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Neck Index Score

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ______________________ **Date** __________

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Back Index Score

PATIENT HISTORY UPDATE

Name________________________ SSN_______________ Signature________________________ Date____________

In order for us to better serve you; we need this important confidential questionnaire answered completely by you. If you need any assistance, please do not hesitate to ask our staff for help. Please write clearly for your own health! Thank you.

Please list and describe your symptoms, problem, condition, diagnosis or other factor that is the reason for your visit to this clinic today.

Are your symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ☐YES☐ NO *If you answered yes, please fill out accident specific form, available at the front desk.*

Please describe in detail how your present illness/symptoms developed/started (suddenly or gradually) from first sign and/or symptom to the present (including location, quality, severity, duration, timing, context, modifying factors and associated signs and symptoms, etc.)

Describe the quality/character of your symptom(s).Some words often used include burning, tingling, aching, tired, numbness, sharp, dull, stabbing, shooting, radiating, pins and needles, etc.

On a pain analog scale of 0 to 10, with 0 being the absence of pain and 10 being significant enough to seek emergency care, which number would describe your pain/discomfort severity? *Please circle.*

What is your pain/discomfort like today?	No Pain	0 -1 -2 -3 -4 -5 -6 -7 -8 -9 -10	Severe Pain
What is your least pain/discomfort?	No Pain	0 -1 -2 -3 -4 -5 -6 -7 -8 -9 -10	Severe Pain
What is your worst pain/discomfort?	No Pain	0 -1 -2 -3 -4 -5 -6 -7 -8 -9 -10	Severe Pain

How much time during an average day are you in pain/discomfort?

☐ Less than 1 hour per day ☐ Between 1 and 4 hours per day ☐Almost anytime when not lying down

☐Almost 24 hours per day ☐ Between 4 and 8 hours per day ☐Other

What made your symptoms better or worse?

Is your sleep disturbed by these symptoms? ☐ YES ☐ NO ☐ Slightly ☐ Moderately ☐ Severely

Have you experienced any restrictions or difficulties in any ACTIVITIES OF DAILY LIVING, SOCAIL and RECREATIONAL ACTIVITIES because of your current condition, please describe in detail (such as bathing, grooming, dressing, eating, walking, stooping, bending, grasping, driving etc) ☐ YES ☐ NO ☐ Slightly ☐ Moderately ☐ Severely

Have you seen a physician or chiropractor outside this clinic for the problem(s) for which you came to this clinic? ☐ YES ☐NO
If yes please list each doctor individually.

How much were your symptoms/discomforts improved or helped? *Please circle.*
No improvement 0—1 —2 —3 —4 —5 —6 — 7—8 — 9— 10 Full improvement

Since your symptoms began, were they ☐ Improved ☐ Worsened ☐Stayed the same?

Who is filling out this questionnaire? ☐Self ☐ Spouse ☐ Other

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient's signature____________________________________ Date: _______________

Physicians signature___________________________________ Date: _______________

Workers' Compensation Board

Employee Claim

State of New York - Workers' Compensation Board

C-3

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: ______________ (First) ______ (MI) ______ (Last) 2. Date of Birth: ____/____/____
3. Mailing address: ______________ (Number and Street/PO Box/Apartment No.) ______ (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): ______________

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

YOUR NAME: ______________________________ (First / MI / Last) DATE OF INJURY/ILLNESS: ____/____/____

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? ____________

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
   If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): ____________
   If your vehicle was involved, give name and address of your motor vehicle insurance carrier: ____________

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
    If yes, notice was given to: ____________ ☐ orally ☐ in writing Date notice given: ____/____/____

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: ____________

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? ____/____/____ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? ____/____/____ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? ____________ How often are you paid? ____________

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? ____/____/____ ☐ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room ☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
   Name and address where you were first treated: ____________
   ____________ Phone Number: (____) ____________
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
   Give the name and address of the doctor(s) treating you for this injury/illness: ____________
   ____________ Phone Number: (____) ____________
5. Do you remember having another injury to the same body part or a similar illness? ☐ Yes ☐ No
   If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
   ____
   ____
   ____
6. Was the previous injury/illness work related? ☐ Yes ☐ No
   If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: ____________ Print Name: ____________ Date: ____/____/____

On behalf of Employee: ____________ Print Name: ____________ Date: ____/____/____

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): ____________ Date: ____/____/____

Print Name: ____________ Title: ____________

ID No., if any: R ____________ If Licensed Representative, License No.: ____________ Expiration Date: ____/____/____

Workers' Compensation Board

Limited Release of Health Information (HIPAA)

State of New York - Workers' Compensation Board

C-3.3

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

Versión en español al reverso de la forma.