

FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_ LAST NAME \_\_\_\_\_

PREFERRED TO BE CALLED \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SSN \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ WORK # \_\_\_\_\_ CELL # \_\_\_\_\_

YOUR OCCUPATION \_\_\_\_\_ REFERRED BY \_\_\_\_\_

YOUR EMPLOYER \_\_\_\_\_ NAME OF SPOUSE \_\_\_\_\_

IF YOU ARE NOT RETIRED, A HOMEMAKER, OR A STUDENT, WHAT IS YOUR CURRENT WORK STATUS?  FULL-TIME  SELF-EMPLOYED  OFF WORK  PART-TIME  UNEMPLOYED  OTHER

IS THIS A GENERAL CHECK-UP/WELL VISIT? YES NO  
IS THIS YOUR FIRST CHIROPRACTIC VISIT? YES NO  
WOMEN: ARE YOU PREGNANT? YES NO  
LAST PHYSICAL EXAM \_\_\_\_\_  
DUE DATE \_\_\_\_\_

1. WHAT IS YOUR MAJOR COMPLAINT? \_\_\_\_\_  
2. WHEN DID YOUR SYMPTOMS START? \_\_\_\_\_ 3. DESCRIBE YOUR SYMPTOMS AND HOW THEY BEGAN: \_\_\_\_\_

4. HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS? 5. INDICATE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS ↓

- CONSTANTLY (76-100% OF THE DAY)
- FREQUENTLY (51-75% OF THE DAY)
- OCCASIONALLY (26-50% OF THE DAY)
- INTERMITTENTLY (0-25% OF THE DAY)

6. WHAT DESCRIBES THE NATURE OF YOUR SYMPTOMS?

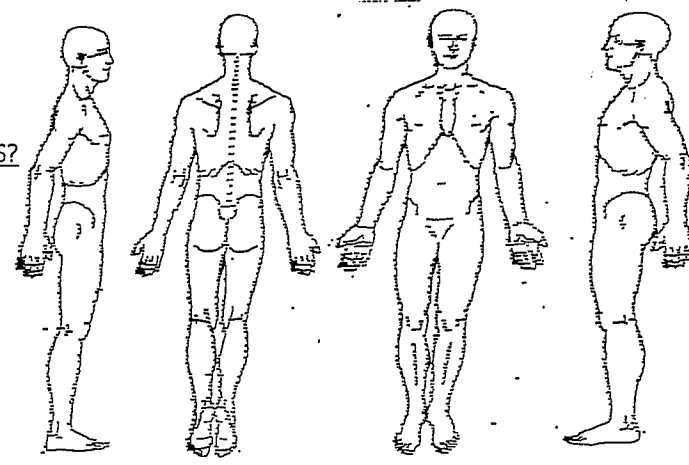
- SHARP  SHOOTING
- DULL ACHE  BURNING
- NUMB  TINGLING

7. HOW ARE YOUR SYMPTOMS CHANGING?

- GETTING BETTER
- NOT CHANGING
- GETTING WORSE

8. HOW BAD ARE YOUR SYMPTOMS AT THEIR:

	NONE										UNBEARABLE
A. WORST:	0	1	2	3	4	5	6	7	8	9	10
B. BEST:	0	1	2	3	4	5	6	7	8	9	10



9. HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? YES NO

- A. IF SO, WHO DID YOU SEE?  THIS OFFICE  MEDICAL DOCTOR  OTHER  
 OTHE CHIROPRACTOR  PHYSICAL THERAPIST

10. WHAT ACTIVITIES MAKE YOUR SYMPTOMS WORSE? \_\_\_\_\_

11. WHAT ACTIVITIES MAKE YOUR SYMPTOMS BETTER? \_\_\_\_\_

12. WHO HAVE YOU SEEN FOR YOUR SYMPTOMS?  NO ONE  MEDICAL DOCTOR  OTHER  
 OTHER CHIROPRACTOR  PHYSICAL THERAPIST

A. WHEN AND WHAT TREATMENT? \_\_\_\_\_

B. WHAT TESTS HAVE YOU HAD FOR YOUR SYMPTOMS AND WHEN WERE THEY PERFORMED?

- XRAYS DATE \_\_\_\_\_  CT SCAN DATE \_\_\_\_\_
- MRI DATE \_\_\_\_\_  OTHER \_\_\_\_\_ DATE \_\_\_\_\_

13. WHAT DO YOU HOPE TO GET FROM YOUR VISIT/TREATMENT? (SELECT ALL THAT APPLY)

- REDUCE SYMPTOMS  EXPLANATION OF CONDITION/TREATMENT  RESUME/INCREASE ACTIVITY
- HOW TO PREVENT THIS FROM OCCURRING AGAIN  LEARN HOW TO TAKE CARE OF THIS ON MY OWN

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

----- OFFICE USE ONLY -----

INS: CASH WC PI PRIVATE INS 1<sup>ST</sup> \_\_\_\_\_ 2<sup>ND</sup> \_\_\_\_\_

# Adirondack Family Chiropractic, P.C.

## Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent and confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

**Vertebral subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment of those findings, we will recommend that you seek the advice of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_ have read  
(print name)

and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

ADIRONDACK FAMILY CHIROPRACTIC, P.C.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective April 14, 2003

The privacy of your medical information is important to us. You may be aware that U.S. governmental regulators established a privacy rule ("HIPAA") governing protected health information. This notice tells you about how it may be used, and about certain rights that you have.

Julie Shiflett, Office Manager is in charge of privacy matters at our office. You can contact her at (518)-561-6004 if you desire further information, or have any questions or concerns.

Use and disclosure of protected information.

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you. We will disclose PHI to other physicians who may be treating you, your PHI may be provided to a physician to whom you have been referred to insure that the physician has the necessary information to diagnosis or treat you.

Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you. Most health plans require us to supply diagnosis and treatment codes and description of services rendered.

Federal law provides that we may use your medical information for health care operations without further specific notice to you, or written authorization by you. We may use your information for financial services, quality assurance, risk reduction and claim management purposes with our medical professional liability insurer.

We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:

1. required by law;
2. required for public health purposes;
3. required by law to report child abuse;
4. required by a health oversight agency for oversight activities authorized by law, such as Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct;
5. required by law in judicial or administrative proceedings;
6. required for law enforcement purposes by a law enforcement official;
7. required by a coroner or medical examiner;
8. permitted by law to a funeral director;
9. permitted by law for organ donation purposes;
10. permitted by law to avert a serious threat to health or safety;
11. permitted by law and required by military authorities if you are a member of the armed forces of the United States.

New York State law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make reasonable requests, in writing, for us to use alternative methods of communication with you in a confidential manner. Space for this provided below.

Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Rights that you have.

You have the right to request restrictions on certain of the uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the request amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make of your medical information, except for: disclosures we make to you, or to carry out treatment, payments or health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR-164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law (or for research or public health purposes after being de-identified or limited to remove personally identifiable information) or disclosures made before April 14, 2003.

If you have received this notice electronically, you have the right to obtain a paper copy from our office.

Obligations that we have.

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. Complaints should be directed to Julie Shiflett, Office Manager, 1942 Military Turnpike, Plattsburgh, New York 12901, (518) 561-6004.

No retaliatory action can be taken against you for any complaint you make.

I have received a paper copy of this notice.

I do not wish to receive a paper copy of this notice at this time.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

I make the following special request for confidential communications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

ADIRONDACK FAMILY CHIROPRACTIC

WORKERS COMPENSATION/NO-FAULT HISTORY

PATIENT NAME: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: M / F SSN: \_\_\_\_\_

EMPLOYER'S NAME: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

1. YOUR OCCUPATION: \_\_\_\_\_ TYPE OF BUSINESS: \_\_\_\_\_

2. DATE OF INJURY/ACCIDENT: \_\_\_\_\_ TIME: \_\_\_\_\_: \_\_\_\_\_ AM / PM STATE: \_\_\_\_\_

3. ARE YOU STILL WORKING? ( ) YES ( ) NO (IF YES) ( ) FULL DUTY OR ( ) WITH RESTRICTIONS  
(IF NO) DATE LAST WORKED: \_\_\_\_\_

4. IN YOUR OWN WORDS, PLEASE FULLY DESCRIBE THE INJURY/ACCIDENT: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. HAS ANOTHER DOCTOR FOR THIS ACCIDENT (INCLUDING PHYSICAL THERAPIST) TREATED YOU? ( ) YES ( ) NO  
(IF YES) PLEASE GIVE DOCTOR'S NAME: \_\_\_\_\_

6. IS THIS DOCTOR STILL TREATING YOU? ( ) YES ( ) NO ARE YOU: ( ) IMPROVING ( ) UNCHANGED ( ) WORSE

7. ARE YOU TAKING ANY MEDICATIONS? ( ) YES ( ) NO DO THEY HELP? ( ) YES ( ) NO

8. PRIOR TO THIS ACCIDENT, HAVE YOU HAD ANY OF THE PHYSICAL COMPLAINTS SIMILAR TO WHAT YOU HAVE NOW? ( ) YES ( ) NO  
(IF YES) DESCRIBE: \_\_\_\_\_

9. WERE THESE SIMILAR COMPLAINTS THE RESULTS OF A PREVIOUS ACCIDENT(S)? ( ) YES ( ) NO  
(IF YES) PLEASE PROVIDE DETAILS OF PREVIOUS ACCIDENT(S): \_\_\_\_\_

10. HAVE YOU HAD ANY PROBLEMS WITH NERVES OR MENTAL ILLNESSES? ( ) YES ( ) NO  
(IF YES) HAVE YOU HAD PSYCHIATRIC CARE? ( ) YES ( ) NO

11. HAVE YOU RECEIVED A MEDICAL DISCHARGE FROM THE ARMED FORCES? ( ) YES ( ) NO

MEDICAL COMPLAINTS PERTAINING TO INJURY/ACCIDENT ONLY

BACK PAIN

- |  |        |               |                     |                |
|--|--------|---------------|---------------------|----------------|
| 1. CURRENTLY, I HAVE PAIN IN MY:             | ( ) NA | ( ) LOW BACK  | ( ) MID BACK        | ( ) UPPER BACK |
| 2. MY PAIN BEGAN:                            | ( ) NA | ( ) GRADUALLY | ( ) SUDDENLY        |                |
| 3. I HAVE PAIN:                              | ( ) NA | ( ) SOMETIMES | ( ) ALL OF THE TIME |                |
| 4. MY PAIN GOES INTO MY:                     | ( ) NA | ( ) RIGHT LEG | ( ) LEFT LEG        | ( ) BOTH       |
| 5. I HAVE TINGLING AND/OR<br>NUMBNESS IN MY: | ( ) NA | ( ) RIGHT LEG | ( ) LEFT LEG        | ( ) BOTH       |
| 6. MY PAIN IS WORSE WHEN I :                 |        |               |                     |                |
| COUGH OR SNEEZE                              | ( ) NA | ( ) YES       | ( ) NO              |                |
| SIT  | ( ) NA | ( ) YES       | ( ) NO              |                |
| BEND   | ( ) NA | ( ) YES       | ( ) NO              |                |
| WALK   | ( ) NA | ( ) YES       | ( ) NO              |                |
| LIFT   | ( ) NA | ( ) YES       | ( ) NO              |                |
| PUSH   | ( ) NA | ( ) YES       | ( ) NO              |                |
| PULL   | ( ) NA | ( ) YES       | ( ) NO              |                |
| 7. MY BACK IS WORSE WITH<br>SEXUAL ACTIVITY: | ( ) NA | ( ) YES       | ( ) NO              |                |

TURN PAGE OVER →



9. ARE YOU EXPOSED TO MARKED CHANGES IN TEMPERATURE AND HUMIDITY? ( ) YES ( ) NO

DESCRIBE: \_\_\_\_\_

10. ARE YOU REQUIRED TO DRIVE AUTOMOTIVE EQUIPMENT? ( ) YES ( ) NO

DESCRIBE: \_\_\_\_\_

11. ARE YOU EXPOSED TO DUST, FUMES AND/OR GASES? ( ) YES ( ) NO

DESCRIBE: \_\_\_\_\_

PLEASE LIST ANY ADDITIONAL COMMENTS RELATED TO YOUR CONDITION: \_\_\_\_\_

**IF YOU RECEIVE ANY INFORMATION PERTAINING TO YOUR WORKERS COMPENSATION/NO-FAULT ACCIDENT (FOR EXAMPLE: LETTERS, PHONE CALLS, E-MAILS, ETC.) YOU WILL NEED TO BRING IT TO THE ATTENTION OF THIS OFFICE!!!**

THIS SECTION IS FOR WORKERS COMPENSATION ONLY!!!  
AFTER COMPLETING THIS SECTION PLEASE SIGN AND DATE THE BOTTOM OF THIS PAGE.

NAME OF COMPENSATION CARRIER: \_\_\_\_\_ PHONE: (\_\_\_\_\_) \_\_\_\_\_

ADDRESS OF CARRIER: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

1. ACCIDENT REPORTED TO EMPLOYER? ( ) YES ( ) NO NAME OF PERSON REPORTED ACCIDENT TO: \_\_\_\_\_

2. INJURED AT: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

3. LENGTH OF TIME WORKED PRIOR TO ACCIDENT: \_\_\_\_\_

4. PREVIOUS WORKERS COMPENSATION INJURY? ( ) YES ( ) NO

**\*\*\*ATTENTION ALL WORKERS' COMPENSATION PATIENTS!\*\*\***

IF ANY CORRESPONDENCE CONCERNING YOUR WORKERS' COMPENSATION CONDITION IS NEEDED FOR ANY OF THE FOLLOWING REASONS:

- COURT HEARINGS
- INDEPENDENT MEDICAL EXAMS
- TRAVEL DATES (\$6.00 CHARGE)
- ATTORNEY REQUEST FOR RECORDS
- DISABILITY FORMS (\$10.00 CHARGE)
- SPECIAL LETTERS (\$5.00-\$10.00 CHARGE)

THIS OFFICE REQUESTS AT LEAST FIVE BUSINESS DAYS NOTIFICATION TO MEET YOUR REQUESTS.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

THIS SECTION IS FOR NO-FAULT ONLY!!!  
AFTER COMPLETING THIS SECTION PLEASE SIGN AND DATE THE BOTTOM OF THIS PAGE.

VEHICLE INFORMATION: 1. MAKE & MODEL OF VEHICLE: \_\_\_\_\_

2. WHOS NAME IS VEHICLE INSURED TO? \_\_\_\_\_

3. INSURANCE AGENT'S NAME: \_\_\_\_\_ PHONE (\_\_\_\_\_) \_\_\_\_\_

**\*\*\*ATTENTION ALL NO-FAULT PATIENTS!\*\*\***

IT IS THE RESPONSIBILITY OF THE PATIENT TO NOTIFY THE APPROPRIATE INSURANCE COMPANY IMMEDIATELY FOLLOWING AN ACCIDENT. AFTER WE HAVE VERIFIED THE NO-FAULT BENEFITS WE WILL BE HAPPY TO SUBMIT ON THE PATIENT'S BEHALF. HOWEVER, AT ALL TIMES, THE PATIENT REMAINS RESPONSIBLE FOR THE ACCOUNT BALANCE.

**\*\*\*PLEASE NOTE THAT NEW YORK STATE IS A NO-FAULT STATE\*\*\***  
ALL MEDICAL BENEFITS ARE PAID THROUGH THE INSURANCE POLICY OF THE OWNER OF THE VEHICLE YOU ARE RIDING IN AT TIME OF ACCIDENT.

**TURN PAGE OVER →**

ADIRONDACK FAMILY CHIROPRACTIC

WORKERS' COMPENSATION AND NO-FAULT PATIENTS PLEASE READ THEN SIGN AND DATE

**ASSIGNMENT OF RELEASE OF INFORMATION STATEMENTS**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION BY ADIRONDACK FAMILY CHIROPRACTIC.

I HEREBY AUTHORIZE AND DIRECT THE ABOVE NAMED, HAVING TREATED ME, TO RELEASE TO GOVERNMENT AGENCIES, INSURANCE CARRIERS, OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY CHIROPRACTIC CARE, ALL INFORMATION NEEDED TO SUBSTANTIATE PAYMENT FOR SUCH CARE AND TO PERMIT REPRESENTATIVE THEREOF TO EXAMINE AND MAKE COPIES OF ALL RECORDS RELATING TO SUCH CARE AND TREATMENT.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

\_\_\_\_\_  
DATE

ASSIGNMENT TO ADDIRONDACK FAMILY CHIROPRACTIC.

I HEREBY ASSIGN, TRANSFER, AND SET OVER TO THE ABOVE NAMED SUFFICIENT MONIES AND/OR BENEFITS TO WHICH I MAY BE ENTITLED FROM GOVERNMENTAL AGENCIES, INSURANCE CARRIERS, OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY CHIROPRACTIC CARE TO COVER THE COSTS OF THE CARE AND TREATMENT RENDERED TO MYSELF OF MY DEPENDENT IN SAID OFFICE.

\_\_\_\_\_  
SIGNATURE OF INSURED OR AUTHORIZED REPRESENTATIVE

\_\_\_\_\_  
DATE

STATE OF NEW YORK  
WORKERS' COMPENSATION BOARD

EMPLOYEE'S CLAIM FOR COMPENSATION

ANSWER ALL QUESTIONS  
FULLY - PRINT OR TYPE  
CLEARLY

IMPORTANT: Your Social Security Number Must Be Entered:  
IMPORTANTE: El Numero de su Seguro Social Debe Ser Indicado:

--	--	--	--	--	--	--	--

WCB Case No. (If known) \_\_\_\_\_ Carrier Case No.(if known) \_\_\_\_\_

A. Injured person	1. Name..... First Name Middle Name Last Name
	2. Mailing Address..... Number and Street (include Apartment No.) City State Zip Code.
	3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth..... Telephone No. ( ).....
	4. Do you speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what language do you speak?.....
	5. Name of union and local number, if member.....
	6. State what your regular work/occupation was.....
	7. Wages or average earnings per day, including overtime, board, rent and other allowances.....
	8. Were you paid full wages for the day of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
	9. Your work week at time of injury was: <input type="checkbox"/> Five day <input type="checkbox"/> Six day <input type="checkbox"/> Seven day <input type="checkbox"/> Other.....
B. Employer(s)	1. Employer..... Telephone No. ( ).....
	2. Employer's Address.....
	3. Were you employed by any other employer or employers at the time of your injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No
	4. If yes, did you lose time from work at this other employment as a result of your injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No
C. Place/Time	1. Address where injury occurred..... County.....
	2. Date of injury..... at..... o'clock, <input type="checkbox"/> AM <input type="checkbox"/> PM
D. The Injury	1. How did injury/illness occur?.....
E. Nature and Extent of Injury/ Illness	1. State fully the nature of your injury/illness, including all parts of body injured.....
	2. Date you stopped work because of this injury/illness?.....
	3. Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, on what date?.....
	4. Does injury/illness keep you from work? <input type="checkbox"/> Yes <input type="checkbox"/> No
	5. Have you done any work during period of disability? <input type="checkbox"/> Yes <input type="checkbox"/> No
	6. Have you received any wages since your injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No
F. Medical Benefits	1. Did you receive or are you now receiving medical care? <input type="checkbox"/> Yes <input type="checkbox"/> No
	2. Are you now in need of medical care? <input type="checkbox"/> Yes <input type="checkbox"/> No
	3. Name of attending doctor..... Doctor's address.....
	4. If you were in a hospital, give the dates hospitalized..... Name of hospital..... Hospital's Address.....
G. Comp. Payments	1. Have you received or are you now receiving workers' compensation payments for the injury reported above? <input type="checkbox"/> Yes <input type="checkbox"/> No
	2. Do you claim further workers' compensation payments? <input type="checkbox"/> Yes <input type="checkbox"/> No
H. Notice	1. Have you given your employer (or supervisor) notice of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
	2. If yes, notice was given <input type="checkbox"/> orally <input type="checkbox"/> in writing, on..... to.....

I hereby present my claim to the Chair, Workers' Compensation Board, for compensation for disability resulting from an accidental injury or occupational disease arising out of and in the course of my employment and not occasioned by my willful intention or solely through intoxication, and in support of it I make the foregoing statement of facts.

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.

Signed by..... Dated.....  
(Claimant)

SEE OTHER SIDE FOR IMPORTANT INFORMATION - VEASE AL DORSO PARA INFORMACION DE IMPORTANCIA

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.  
LA JUNTA DE COMPENSACION OBRERA EMPLEA Y SIRVE A PERSONAS INCAPACITADAS SIN DISCRIMINAR.

**WHAT EVERY WORKER SHOULD DO IN CASE OF ON-THE-JOB INJURY OR OCCUPATIONAL DISEASE.**

1. Immediately tell your employer or supervisor when, where and how you were injured.
2. Secure medical care immediately.
3. Tell your doctor to file medical reports with the Board and with your employer or its insurance carrier.
4. Make out this claim for compensation and send it to the nearest Workers' Compensation Board Office. (See below.) Failure to file within two years after the date of injury may result in your claim being denied. If you need help in completing this form, telephone or visit the nearest Workers' Compensation Board Office listed below.
5. Go to all hearings when notified to appear.
6. Go back to work as soon as you are able; compensation is never as high as your wage.

**YOUR RIGHTS:**

1. Generally, you are entitled to be treated by a doctor of your choice, provided he/she is authorized by the Board. If your employer is involved in a preferred provider organization (PPO) arrangement, you must obtain initial treatment from the preferred provider organization which has been designated to provide health care services for workers' compensation injuries.
2. DO NOT pay your doctor or hospital. Their bills will be paid by the insurance carrier if your case is not disputed. If your case is disputed, the doctor or hospital must wait for payment until the Board decides your case. In the event you fail to prosecute your case or the Board decides against you, you will have to pay the doctor or hospital.
3. You are also entitled to be reimbursed for drugs, crutches, or any apparatus properly prescribed by your doctor and for car fares or other necessary expenses going to and from your doctor's office or the hospital. (Get receipts for such expenses.)
4. You are entitled to compensation if your injury keeps you from work for more than seven days, compels you to work at lower wages, or results in permanent disability to any part of your body.
5. Compensation is payable directly and without waiting for an award, except when the claim is disputed.
6. You are entitled to a hearing. You are not required to obtain anyone to represent you at a hearing, but you have the right to be represented by an attorney or licensed representative, if you so choose. If you obtain representation, do not pay your attorney or representative directly. When the Workers' Compensation Board rules on your case, the attorney's or representative's fee will be set by the Board and paid to him or her by your employer or by your employer's insurance carrier. The amount so paid will be deducted from your award.
7. If you need help returning to work, or with family or financial problems because of your injury, contact the Workers' Compensation Board office nearest you and ask for a rehabilitation counselor or social worker.

**LO QUE TODO TRABAJADOR DEBE HACER EN CASO DE LESION O ENFERMEDAD OCUPACIONAL.**

1. Avisar inmediatamente a su patrono ó a su supervisor cuando, donde y como sufrió la lesión.
2. Obtener atención médica inmediatamente.
3. Pedirle a su médico que presente informes a la Junta y a su patrono, ó a la compañía de seguros.
4. Llenar esta forma de reclamación para compensación y enviarla a la oficina mas cercana de la Junta de Compensación. (vease abajo.) El no presentar reclamación dentro de dos años a partir de la fecha de la lesión puede ser motivo de que se le rechace la reclamación. Si necesita que le ayuden a llenar esta forma, llame por telefono o vaya a la oficina mas cercana de la Junta de Compensación Obrera.
5. Acudir a todas las audiencias cuando se le notifique que comparezca.
6. Volver a su trabajo lo mas pronto que le sea posible; la compensación nunca es tan alta como su sueldo.

**SUS DERECHOS:**

1. Por lo general usted tiene derecho a ser atendido por el médico de su preferencia, siempre y cuando esté autorizado por la Junta. Si su patrono está participando en un acuerdo de organización de proveedores con preferencia (P.P.O.) su tratamiento inicial deberá obtenerlo de la entidad que su patrono haya designado para proveer cuidado médico para lesiones relacionadas con la compensación obrera.
2. NO PAGUE NADA a su médico ni al hospital. Esas facturas serán pagadas por la compañía de seguros si su caso no ha sido cuestionado. Si el caso es disputado, su médico y el hospital deberán esperar hasta que la Junta decida el caso. Si usted dejara de proseguir su caso o si la Junta fallara en su contra, le corresponde pagar a su médico y al hospital.
3. También tiene usted derecho a ser reembolsado por gastos de medicamentos, muletas o cualquier aparato apropiadamente prescrito por su médico y por transporte u otros gastos necesarios para visitar el consultorio de su médico ó el hospital. (obtenga comprobantes de esos gastos.)
4. Usted tiene derecho a compensación si su lesión le deja impedido de trabajar por mas de siete días, o le obliga a trabajar a sueldo mas bajo ó resulta con incapacidad permanente en alguna parte de su cuerpo.
5. La compensación es pagadera directamente y sin tener que esperar la decisión, excepto cuando se cuestione la reclamación.
6. Usted tiene derecho a una audiencia. Usted no está obligado a conseguir quien le represente en la audiencia, pero tiene derecho a ser representado por un abogado o por un representante licenciado, si usted lo prefiere. En caso de obtener usted representación, no pague nada directamente a su abogado o representante. Cuando la Junta de Compensación Obrera decida su caso, los honorarios de su abogado o representante serán fijados por la Junta y serán pagados por el patrono ó por la compañía de seguros. La suma pagada en esta forma será deducida de la cantidad adjudicada a usted.
7. Si necesita ayuda para volver al trabajo, ó si tiene problemas familiares o economicos por motivo de su lesión, comuníquese con la oficina de la Junta de Compensación Obrera que le quede mas cerca y pida una reunión con un consejero de rehabilitación o con un trabajador social.

**WORKERS' COMPENSATION BOARD DISTRICT OFFICES AND COUNTIES SERVED**

**OFICINAS DE DISTRITO DE LA JUNTA DE COMPENSACION OBRERA Y LOS CONDADOS SERVIDOS**

- ALBANY 12241 - 100 Broadway, Menands. (866) 750-5157** For all accidents in following counties: Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Ulster, Warren, Washington.
- BINGHAMTON 13901 - State Office Building, 44 Hawley Street (866) 802-3604** For all accidents in following counties: Broome, Chemung, Chenango, Cortland, Delaware, Otsego, Schuyler, Sullivan, Tioga, Tompkins.
- BUFFALO 14202 - Statter Towers, 107 Delaware Ave. (866) 211-0645** For all accidents in following counties: Cattaraugus, Chautauqua, Erie, Niagara.
- ROCHESTER 14614 - 130 Main Street West. (866) 211-0644** For all accidents in following counties: Allegany, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, Yates.
- SYRACUSE 13203 - 935 James Street. (866) 802-3730** For all accidents in following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence.
- DOWNSTATE CENTRALIZED MAILING (for New York City, Hempstead, Hauppauge & Peekskill district offices) - PO Box 5205, Binghamton, NY 13902-5205. NYC (800) 877-1373 Hemp. (866) 805-3630** Haup. (866) 681-5354 Peek. (866) 746-0552 For all accidents in following counties: Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester.

(Claims for compensation, inquiries, medical and other reports should be sent to the District Office of the County in which the accident occurred. Be sure to notify this office of any change in your address.)

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. Sec. 552a).

The Workers' Compensation Board's ("Board") authority to request personal information from claimants is derived from Sections 20 and 142 of the Workers' Compensation Law. This information is collected to assist the Board in processing claims in an efficient manner and to help it maintain accurate claim records.

The Board is strictly committed to protecting the confidentiality of all personal information that it collects. Such information will be disclosed within the agency only to Board personnel and agents in furtherance of their official duties. Personal information will be disclosed outside the agency only in accordance with applicable state and federal law.

The Board's Director of Operations, located at 100 Broadway, Menands, New York 12241 (518-474-6674), is primarily responsible for the maintenance of agency records containing personal claimant information.

Failure to provide the information requested on this form will not result in the denial of your claim, but may delay the processing of your claim. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your claim.

**HIPAA Notice**

In order to adjudicate a workers' compensation claim, WCL13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

The Workers' Compensation Board assures hearing locations accessible to the disabled. Contact the nearest Board office if you have special accessibility needs.

Notificación conforme a la Ley de Protección de la Privacidad de Nueva York [Ley de Servidores Públicos 6-A] y el Acta Federal de Privacidad de 1974 [5 U.S.C. Sec. 552a].

La autoridad de la Junta de Compensación Obrera para requerir información personal de los reclamantes surge de las Secciones 20 y 142 de la Ley de Compensación Obrera. Esta información se utiliza para ayudar a la Junta a procesar reclamaciones en forma eficiente y mantener expedientes precisos.

La Junta guarda celosamente la información confidencial de la información personal que requiere. Esa información solo se comparte con personal de la Junta y sus agentes en relación al cumplimiento de sus deberes oficiales. Información personal recopilada por la Junta solo será compartida con personas o entidades fuera de la Junta cuando sea requerido por leyes estatales o federales.

El Director de Operaciones de la Junta con oficinas en 100 Broadway, Menands, New York 12241 (518-474-6674), es responsable directo del mantenimiento de los expedientes de la agencia que contienen información personal de los reclamantes.

Si usted no suministra la información requerida en esta forma, esto no quiere decir que su reclamación será denegada, pero puede retrasar el procesamiento de su caso. El tener su seguro social permite a la Junta tomar acción rápida en todo lo concerniente a la información relacionada con su reclamación.

**Aviso de HIPAA**

Como requisito para adjudicar una reclamación, la ley de compensación obrera WCL 13-a(4) (a) y 12 NYCRR 325-1.3 requiere a los proveedores de salud radicar regularmente ante la Junta, el asegurador o el patrono informes sobre el tratamiento médico. Conforme a 45CFR 164.512 estos informes médicos requeridos por ley están exentos de las restricciones sobre información médica impuestos por HIPAA.

Proveemos locales accesibles para la vista de sus casos. Comuníquese con nuestra oficina mas cercana si tienes algun requerimiento especial de acceso.

**NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF  
FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED,  
OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED**

WCB CASE NO. (If Known)		CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.
CLAIMANT	NAME			ADDRESS	APT. NO.
EMPLOYER					
INSURANCE CARRIER					

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Provider's Name and Address \_\_\_\_\_

**TO THE CLAIMANT**

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

**Workers' Compensation Law Section 32**

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

**TO THE HEALTH CARE PROVIDER**

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. Do not file with the Workers' Compensation Board. You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.

State of New York  
**WORKERS' COMPENSATION BOARD**

**CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS**

(Pursuant to Workers' Compensation Law Section 110-a)

**PLEASE COMPLETE ALL ITEMS. AN INCOMPLETE FORM WILL DELAY THE PROCESSING OF YOUR REQUEST.**

Claimant's Name	Claimant's Social Security No.	Case Number <input type="checkbox"/> WCB <input type="checkbox"/> DB <input type="checkbox"/> Discrimination and/or Date of Accident
IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC CASE NUMBER AND/OR DATE OF ACCIDENT(S).		
CLAIMANT IS PROHIBITED FROM AUTHORIZING RELEASE OF WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT.		

**INSTRUCTIONS:**  
 Submit original to the Workers' Compensation Board and retain a copy for your records. *Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form.* This authorization is effective until it is revoked by the claimant. Claimant may revoke this authorization at any time upon written notice to the Workers' Compensation Board.  
**THIS AUTHORIZATION DOES NOT PERMIT eCASE ACCESS.**

Pursuant to Section 110-a of the Workers' Compensation Law, I, \_\_\_\_\_, Claimant's Name  
 represent that I am a person who is/was the subject of the Workers' Compensation case(s) indicated above,  
 and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to \_\_\_\_\_, at  
 Name of a Specific Person, Corporation, Association or Public or Private Entity  
 \_\_\_\_\_, at  
 Address

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

\_\_\_\_\_  
 Claimant's Signature (ink only) Date

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.

Pursuant to Workers' Compensation Law Section 110-a:

3. Individual authorization. Notwithstanding the restrictions on disclosure set forth under subdivision one of this section, a person who is the subject of a workers' compensation record may authorize the release, re-release or publication of his or her record to a specific person not otherwise authorized to receive such record, by submitting written authorization for such release to the board on a form prescribed by the chair or by a notarized original authorization specifically directing the board to release workers' compensation records to such person. However, in accordance with section one hundred twenty-five of this article, no such authorization directing disclosure of records to a prospective employer shall be valid; nor shall an authorization permitting disclosure of records in connection with assessing fitness or capability for employment be valid, and no disclosure of records shall be made pursuant thereto. It shall be unlawful for any person to consider for the purpose of assessing eligibility for a benefit, or as the basis for an employment-related action, an individual's failure to provide authorization under this subdivision.

4. It shall be unlawful for any person who has obtained copies of board records or individually identifiable information from board records to disclose such information to any person who is not otherwise lawfully entitled to obtain these records.

5. Any person who knowingly and willfully obtains workers' compensation records which contain individually identifiable information under false pretenses or otherwise violates this section shall be guilty of a class A misdemeanor and shall be subject upon conviction, to a fine of not more than one thousand dollars.

6. In addition to or in lieu of any criminal proceeding available under this section, whenever there shall be a violation of this section, application may be made by the attorney general in the name of the people of the state of New York to a court or justice having jurisdiction by a special proceeding to issue an injunction, and upon notice to the defendant of not less than five days, to enjoin and restrain the continuance of such violations; and if it shall appear to the satisfaction of the court or justice that the defendant has, in fact, violated this section, an injunction may be issued by such court or justice, enjoining and restraining any further violation, without requiring proof that any person has, in fact, been injured or damaged thereby. In any such proceeding, the court may make allowances to the attorney general as provided in paragraph six of subdivision (a) of section eighty-three hundred three of the civil practice law and rules, and direct restitution. Whenever the court shall determine that a violation of this section has occurred, the court may impose a civil penalty of not more than five hundred dollars for the first violation, and not more than one thousand dollars for the second or subsequent violation within a three year period. In connection with any such proposed application, the attorney general is authorized to take proof and make a determination of the relevant facts and to issue subpoenas in accordance with the civil practice law and rules.