PATIENTS SUBJECTIVE COMPLAINTS QUESTIONNAIRE

Did another health provider treat this injury/illness including hospitalization and/or surgery? Yes/No

If yes, how/when: _____

_____

(PLEASE INDICATE WITH AN "X" FOR YES)

	NUMBNESS/TINGLING		SWELLING
	PAIN		WEAKNESS
	STIFFNESS		DIZZINESS
	SWAYING/TILTING		DIFFICULTY WALKING
	FAINTNESS		LOSS OF BALANCE
	DOUBLE VISION		RINGING IN THE EARS
	HEADACHES		CHEST PAINS
	OTHER		

(TYPE/NATURE OF INJURY, PLEASE INDICATE WITH AN "X" FOR YES)

	ABRASION		INFECTIOUS DISEASE
	AMPUTATION		INHALATION EXPOSURE
	AVULSION		LACERATION
	BITE		BURN
	NEEDLE STICK		POISONING/TOXIC EFFECTS
	CONTUSION/HEMATOMA		DISLOCATION
	HERNIA		SPRAIN/STRAIN
	FRACTURE		PUNCTURE WOUND
	OTHER		

ARE YOUR SYMPTOMS AFFECTED OR BROUGHT ON BY ANY OF THE FOLLOWING?

---- CHANGE IN POSITION
---- RAPID HEAD MOVEMENT
---- STANDING UP
---- WALKING IN DARK OR DIMLY LIT ROOM
---- WALKING ON UNEVEN SURFACES
---- TRAVELING IN A CAR, AIRPLANE OR BOAT
---- CLIMBING STAIRS OR LADDER
---- COUGHING, SNEEZING, STRAINING
---- WATCHING MOVING OBJECTS
---- SMOKING
---- ALCOHOL
---- CERTAIN MEDICATIONS _____

DO YOU REQUIRE EYE GLASSES? YES / NO
DO YOU REQUIRE A HEARING AID? YES / NO
DO YOU USE A CANE AND/OR WALKER? YES/ NO

PLEASE LIST CURRENT MEDICATIONS

_____

_____

_____

CLAIMANT'S AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(Pursuant to HIPAA)

INSTRUCTIONS
To the Claimant: The Health Insurance Portability and Accountability Act of 1996 (HIPM) set standards for guaranteeing the privacy of individually identifiable health information and the confidentiality of patient medical records. By completing and signing this form, you authorize your health care provider to file medical reports with the parties that you choose (such as the Workers' Compensation Board, your employer's insurance carrier, your attorney or representative, etc.) by checking the appropriate boxes below.

You have the right to refuse to sign this Authorization. If you sign, you have the right to revoke this Authorization at any time by mailing a request to revoke to the health care provider. You have the right to receive a copy of this Authorization.

IMPORTANT: Failure to execute this authorization may interfere with your ability to obtain workers' compensation benefits.

CLAIMANTS NAME	CLAIMANTS SOCIAL SECURITY NUMBER	CLAIMANTS DATE OF BIRTH

LIST ALL WCB CASE NUMBER(S) AND CORRESPONDING DATE(S) OF ACCIDENT FOR WHICH YOU ARE GRANTING AUTHORIZATION

I, _____ hereby authorize my treating health provider,
Claimant's Name

_____ to disclose the following described health information:
Health Provider's Name

_____

_____

_____

This information can be disclosed to the following parties: *(check all that apply; give names and addresses, if known)*

D New York State Workers' Compensation Board

D My current/former employer _____

D Workers' compensation insurance carrier(s) _____

D Third-party administrator _____

O My attorney/licensed representative _____

D The Uninsured Employer's Fund (this fund is responsible for paying the medical bills and lost wage benefits when an employer is uninsured.)

D Special Funds Conservation Committee (for cases under Section 25-a or 15-B of the Workers' Compensation Law)

Section 25-a: If your claim is being reopened after being previously closed, the Special Fund for Reopened Cases may be responsible for paying your medical bills and lost wage benefits.

Section 15-8: If you had a medical condition that existed prior to this injury, the Special Fund for Second Injuries may be responsible for reimbursing your employer's insurance carrier aft• ar a period oftime has elapsed.

Redisclosure: I understand that once the above-referenced health care provider discloses health information based on this Authorization, that health information is no longer protected by HIPAA and the Privacy Rule.
Expiration Date: This Authorization expires upon the final closing of the workers' compensation claim(s) for which it is executed.

I have had the opportunity to review and understand the content of this Authorization. By signing this Authorization, I confirm that it accurately reflects my wishes.

Printed Name of Claimant or Legal Representative	Signature of Claimant or Legal Representative	Date

If Authorization signed by a legal representative on behalf of claimant, state relationship to claimant and basis for authority (e.g. claimant is a minor; patient is deceased and representative is the claimant in a workers' compensation proceeding or represents the estate) _____

TO THE HEALTH PROVIDER: Keep the original of this Authorization on file. A copy must be given to the patienUclaimant upon request. DO NOT SEND TO THE NEW YORK STATE WORKERS' COMPENSATION BOARD.

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.

WORKERS' COMPENSATION BOARD

CENTRALIZED MAILitljG, PO Box 5205, Binghamton, NY 13902-5205

State of New York
WORKERS' COMPENSATION BOARD

CLAIMANTS 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 Owes Doe DDiscrimination and/or Date of Accident

IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/08/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 YOU TO OPEN AN INDIVIDUAL eCASE ACCOUNT OR TO VIEW CASES VIA eCASE OUTSIDE OF A BOARD LOCATION.

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

_____ 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-- use blue ballpoint pen if possible) 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.