Workers Compensation Injury Form

Strong Spine Chiropractic

25 Harrison St. Jamestown, NY

Employer Information

- **Employer's Name:**_____
- **Employer's Address:**_____
- **Job Title:** _____
- **Phone Number:**_____
- **Supervisors Name:** _____

Workers Compensation Insurance Information:

- **Claim Number:**_____
- **WCB Case Number:**_____
- **Insurance Carrier Name:**_____
- **Adjuster Name:**_____
- **Adjuster Phone Number:**_____

Date of Injury:_____

If your injury involved LIFTING, complete this section:

From where were you lifting an object?

☐ A surface below ground level
☐ Ground level
☐ A surface 1 to 3 feet high
☐ A surface 3 to 5 feet high
☐ A surface above 5 feet high

How many pounds was the object you were lifting?

☐ 1 to 5 pounds
☐ 5 to 10 pounds
☐ 10 to 20 pounds
☐ 20 to 40 pounds
☐ 40 to 60 pounds
☐ Over 60 pound

If your injury involved FALLING, complete this section:

From where did you fall at work?

☐ Onto the ground while walking
☐ Onto the ground while running
☐ From 1 to 3 feet high
☐ From 3 to 5 feet high
☐ From 5 to 8 feet high
☐ From higher than 8 feet

What part of your body did you land on?

☐ Head
☐ Right Arm
☐ Left Arm
☐ Right Shoulder
☐ Left Shoulder
☐ Right Hand
☐ Left Hand
☐ Right Buttock
☐ Left Buttock
☐ Tail Bone
☐ Right Hip
☐ Left Hip
☐ Right Leg
☐ Left Leg
☐ Right Knee
☐ Left Knee
☐ Right Foot
☐ Left Foot

What other areas of your body were affected by your fall?

☐ Head
☐ Neck
☐ Right Arm
☐ Left Arm
☐ Right Shoulder
☐ Left Shoulder
☐ Right Hand
☐ Left Hand
☐ Right Buttock
☐ Left Buttock
☐ Tail Bone
☐ Right Hip
☐ Left Hip
☐ Right Knee
☐ Left Knee
☐ Right Foot
☐ Left Foot
☐ Back

Job Work-Related Activities:

What regular activities do you perform at work?

☐ Sitting
☐ Standing
☐ Running
☐ Bending/Stooping
☐ Climbing
☐ Kneeling
☐ Walking
☐ Driving
☐ Lifting
☐ Squatting
☐ Crawling
☐ Crouching
☐ Reaching above shoulders
☐ Pushing/Pulling

How much do you regularly lift at your job?

☐ Little to none
☐ 1 to 10 lbs.
☐ 10 to 20 lbs.
☐ 20 to 40 lbs.
☐ 40 to 60 lbs.
☐ 60 to 80 lbs.
☐ 80 to 100 lbs.
☐ Over 100 lbs.

How many hours do you regularly perform the following activities

Sitting:
☐ 1-2 hours
☐ 2-4 hours
☐ 4-6 hours
☐ 6-8 hours

Walking:
☐ 1-2 hours
☐ 2-4 hours
☐ 4-6 hours
☐ 6-8 hours

Standing:
☐ 1-2 hours
☐ 2-4 hours
☐ 4-6 hours
☐ 6-8 hours

Lifting:
☐ 1-2 hours
☐ 2-4 hours
☐ 4-6 hours
☐ 6-8 hours

Describe injury in your own words:

_____
_____
_____
_____

Did you report the injury to your employer?

☐ Yes
☐ No

Name of person the injury was reported to:_____

Have you lost any days from work, and if so, what dates?
_____to_____.

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

INSTRUCTIONS

To the Claimant: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) 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.

CLAIMANT'S NAME	CLAIMANT'S SOCIAL SECURITY NUMBER	CLAIMANT'S 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)*

☐ New York State Workers' Compensation Board

☐ My current/former employer _____

☐ Workers' compensation insurance carrier(s) _____

☐ Third-party administrator _____

☐ My attorney/licensed representative _____

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

☐ Special Funds Conservation Committee (for cases under Section 25-a or 15-8 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 after a period of time 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 patient/claimant 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)	CLAIM ADMIN CLAIM NUMBER (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	CLAIMANT'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 health care 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 insurer/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 health care provider 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 insurer may not be required to pay the provider'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 their 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 their employer or its insurance carrier settling their case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or insurer 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 their 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 they 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 insurer of liability for medical treatment is approved.