INTAKE WC NF PI

DATE__________ **NAME** ____

1. DOA__________ HOW DID THE ACCIDENT HAPPEN? ______________________________

____

____

____

Which body parts were injured? ____

Which is you main problem? ____

2. **TRANSPORTED** BY :

o Ambulance o Helicopter o Family o Own vehicle o Self

3. YOU WERE **FIRST TREATED** AT:

o The EMERGENCY ROOM o A DOCTORS OFFICE o SELF CARE □ICE □HEAT □OTC meds

4. **PREVIOUS SYMPTOMS**, before this accident you had:

o Similar symptoms o Same symptoms o No symptoms like this o On and off similar symptoms

5. CIRCLE IF YOU HAVE SUFFERED **OTHER ACCIDENTS**:

- o Date: __________ Body parts injured ____________________ □Work related □MVA □Other
- o Date: __________ Body parts injured ____________________ □Work related □MVA □Other
- o Date: __________ Body parts injured ____________________ □Work related □MVA □Other

6. **EMPLOYMENT** AT THE TIME OF THE ACCIDENT Your occupation was? ____________________

BEFORE the accident YOU WERE □Working FT □Working PT □Not Working □Disabled □SSD

AFTER the accident YOU have been □Working FT □Working PT □Not Working □Disabled □SSD

7. CIRCLE IF YOUR **SYMPTOMS ARE RELIEVED BY**:

o HEAT o ICE o MOVEMENT o PAIN MEDS o REST

8. WHAT MAKES YOUR **SYMPTOMS GET WORSE**?

o ACTIVITY
o STAIRS
o BEND
o COUGH
o DRIVING
o LIFTING
o RAISE ARMS OVER HEAD
o SIT 15min 30min 1hr
o STAND 15min 30min 1hr
o WALK 5min 15min 30min 1hr
o WORK

9. Have you seen **OTHER DOCTORS FOR THIS PROBLEM**? □No

Dr's name: ____________________ Date ________ Treatment ____________________

Dr's name: ____________________ Date ________ Treatment ____________________

10. HAVE YOU HAD **TESTS DONE FOR THIS PROBLEM**? □No

MRI of: ______________ Date __________ Findings____________________

X-ray of: ______________ Date __________ Findings____________________

Other ______________ Date __________ Findings____________________

INTAKE WC NF PI

DATE__________ NAME ____

11. Have you had **SURGERY FOR THIS PROBLEM?** ☐No
    Surgery type: ______________________________ Date of surgery: ______________
    Surgery type: ______________________________ Date of surgery: ______________

12. Have you had **PHYSICAL THERAPY FOR THIS PROBLEM?** ☐No ☐Yes; From __________ to __________

OTHER MEDICAL PROBLEMS not related to this accident:

1. High Blood Pressure
2. Diabetes
3. Asthma
4. Cancer
5. Ulcers
6. Arthritis
7. Heart Disease
8. Kidney Disease
9. Depression/Anxiety
10. Osteoporosis

☐ **I HAVE NO** MEDICAL PROBLEMS

OTHER SURGERIES not related to this accident:
☐NONE

1. ______________________ Date ________
2. ______________________ Date ________

LIST ALL **MEDICATIONS AND SUPPLEMENTS YOU TAKE DAILY**: ☐LIST ATTACHED ☐**I TAKE NO** MEDICATIONS

1. .______________________ 6. .______________________
2. .______________________ 7. .______________________
3. .______________________ 8. .______________________
4. .______________________ 9. .______________________
5. .______________________ 10..______________________

MEDICATION ALLERGIES: ☐ **I HAVE NO MEDICATION ALLERGIES**

1. ______________________
2. ______________________
3. ______________________
4. ______________________

CIRCLE IF **YOU ARE EXPERIENCING**:

- Difficulty to hold/pass urine
- Weight Loss without dieting
- Pain that Wakes You Up
- Unexplained fever

CIRCLE IF **YOU HAVE**:

1. Difficulty Walking
2. Difficulty with Stairs
3. Difficulty getting in/out the car
4. Do you Live alone? ☐Yes ☐No
5. Do you Drive? ☐Yes ☐No

IF YOU HAVE BEEN IN PAIN FOR THREE (3) MONTHS OR MORE PLEASE COMPLETE A PAIN INTAKE

I have reviewed & discussed all above information with the patient Doctor's Signature ______________________

INTAKE (Page 2 of 2) **DATE**____________ **NAME** ____

MEDICATION ALLERGIES ☐ I have **NO** medication allergies

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________

YOUR MEDICAL PROBLEMS Circle if you have/had:

1. High Blood Pressure
2. Diabetes
3. Asthma
4. Cancer
5. Ulcers
6. Arthritis
7. Heart Disease
8. Kidney Disease
9. Depression/Anxiety
10. Osteoporosis

FAMILY HISTORY Circle the following if applys:

1. High Blood Pressure
2. Diabetes
3. Asthma
4. Cancer
5. Ulcers
6. Arthritis
7. Heart Disease
8. Kidney Disease
9. Depression/Anxiety
10. Osteoporosis

SOCIAL HISTORY:

Marital status: ☐Married ☐Single ☐Divorced
Do you Live alone? ☐Yes ☐No
Do you Drive? ☐Yes ☐No

PERSONAL HABITS:

Are you a current smoker? ☐Yes ☐No
Alcohol use? ☐Yes ☐No
Drug use? ☐Yes ☐No

EMPLOYMENT

Your occupation is? __________________ ☐ Unemployed

1. ☐Working FT ☐Working PT ☐ Retired
2. ☐ Disabled ☐ On leave

CIRCLE IF YOU ARE **EXPERIENCING**:

- Difficulty to hold/pass urine
- Weight Loss without dieting
- Pain that Wakes You Up
- Unexplained fever

CIRCLE IF **YOU HAVE**:

1. Difficulty Walking
2. Difficulty with Stairs
3. Difficulty getting in/out the car

(I have reviewed & discussed all above information with the patient)

Doctor's Signature ______________________________________

CHRONIC PAIN
Questionnaire

FILL THIS FORM ONLY IF YOU HAVE BEEN IN PAIN FOR 3 MONTHS OR MORE

 NAME: **DATE:**

Circle the words that describe your pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable
Intermittent	Continuous	Tingling

Circle the number that best describes your PAIN AT IT'S **WORST DURING THE LAST MONTH.**

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worse Pain

Circle the number that best describes your PAIN AY IT'S **LEAST DURING THE LAST MONTH.**

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worse Pain

Circle the number that best describes your PAIN **ON AVERAGE DURING THE LAST MONTH.**

0 1 2 3 4 5 6 7 8 9 10

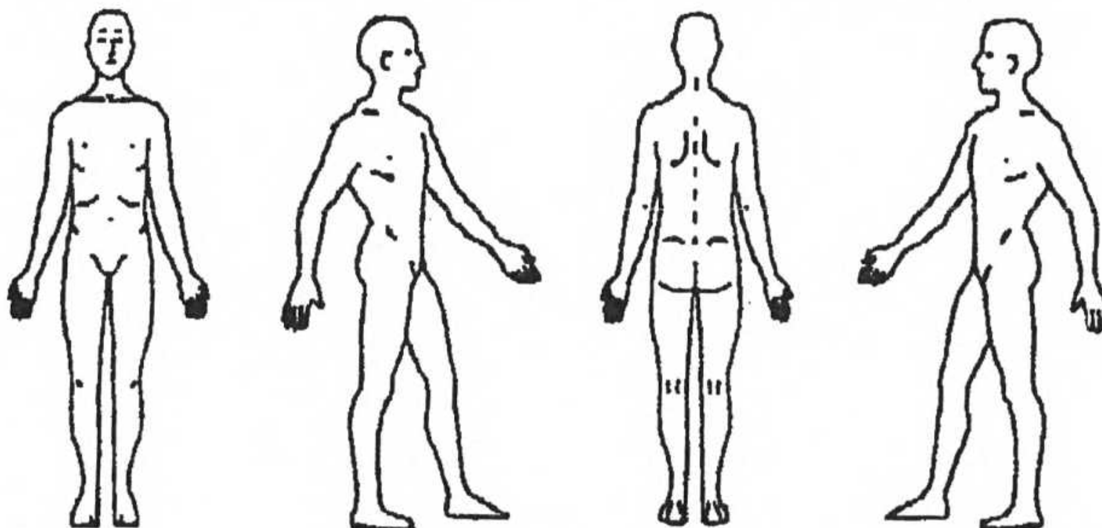
No Pain — Worse Pain

Circle the number that best describes your PAIN AS IT IS **RIGHT NOW.**

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worse Pain

On the diagram below,
SHADE THE AREA(s) WHERE YOU FEEL PAIN. **"X" THE AREAS THAT HURT THE MOST.**



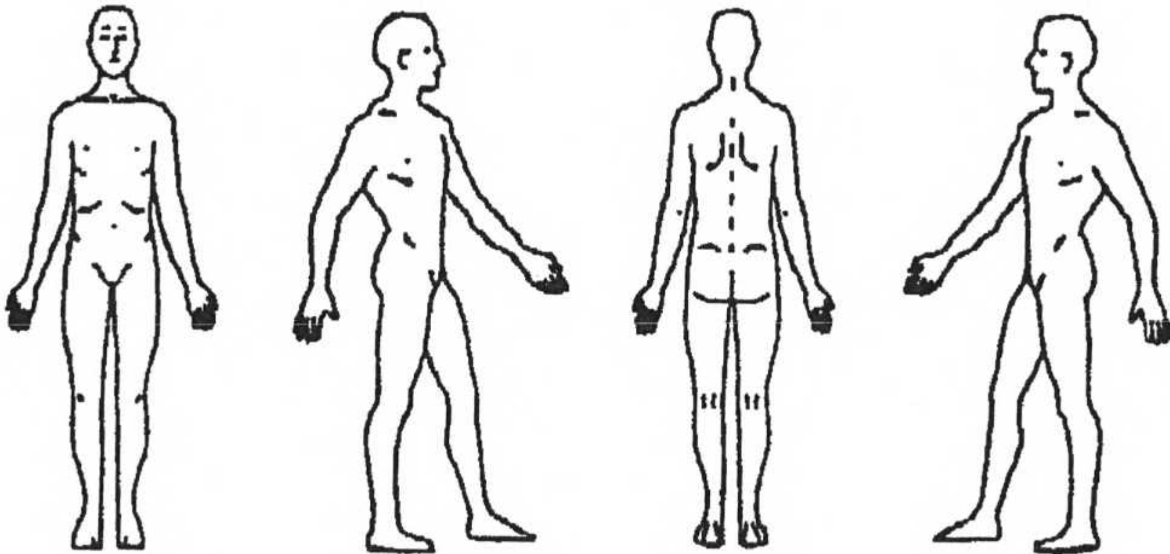
CHRONIC PAIN
Questionnaire

 NAME: **DATE:**

WHAT PAIN TREATMENTS OR MEDICATIONS ARE YOU RECEIVING NOW OR HAVE RECEIVED IN THE PAST? (For example, pain medications, physical therapy, acupuncture, TENS, etc.) Circle the number that best describes the amount of pain relief that the medication or treatment is providing or has provided.

Medication or Treatment now	Not Good										Very Good	Check if taking
______	0	1	2	3	4	5	6	7	8	9	10	◯
______	0	1	2	3	4	5	6	7	8	9	10	◯
______	0	1	2	3	4	5	6	7	8	9	10	◯
______	0	1	2	3	4	5	6	7	8	9	10	◯
______	0	1	2	3	4	5	6	7	8	9	10	◯
______	0	1	2	3	4	5	6	7	8	9	10	◯

On the diagram below, shade the area(s) where you feel **numbness and/or tingling**. Mark with an **"X"** where **numbness and/or tingling feel worse**



CHRONIC PAIN
Questionnaire

 NAME: **DATE:**

Circle the numbers below that best describe how pain has interfered with your daily functioning.

	"0" DOES NOT INTERFERE										TOTALLY INTERFERES "10"
Self Care Activities	0	1	2	3	4	5	6	7	8	9	10
House Chores	0	1	2	3	4	5	6	7	8	9	10
Normal Work Routine	0	1	2	3	4	5	6	7	8	9	10
Walking Ability	0	1	2	3	4	5	6	7	8	9	10
Sleep	0	1	2	3	4	5	6	7	8	9	10
Sexual activity	0	1	2	3	4	5	6	7	8	9	10
Appetite	0	1	2	3	4	5	6	7	8	9	10
Ability to Concentrate	0	1	2	3	4	5	6	7	8	9	10
Mood	0	1	2	3	4	5	6	7	8	9	10
Relations With Other People	0	1	2	3	4	5	6	7	8	9	10
Enjoyment of Life	0	1	2	3	4	5	6	7	8	9	10

WHAT LEVEL OF PAIN, DO YOU THINK, WOULD ALLOW YOU TO FUNCTION ON A DAILY BASIS?

0 1 2 3 4 5 6 7 8 9 10

No Pain **Worse Pain**

SUBSTANCE USE:

Which of the following drugs or substances, if any, have you **USED IN THE PAST?** (Circle all that apply)

Next to each drug or substance that you've circled, indicate if you used it:
Occasionally ("O"), Frequently ("F"), or Continuously ("C").

Alcohol _______	Barbiturates _________	Cocaine __________
Heroin________	Amphetamines_______	Marijuana_________
Other ________	Other ______________	Other ____________

Are you **PRESENTLY USING** any of the drugs or substances below? (Circle all that apply)
Next to each drug or substance that you've circled, indicate if you use it :

Occasionally ("O"), Frequently ("F"), or Continuously ("C").

Alcohol _______	Barbiturates _________	Cocaine __________
Heroin________	Amphetamines_______	Marijuana_________
Other ________	Other ______________	Other ____________

I have reviewed & discussed all above information with the patient, Doctor's Signature ________________________

DOWNSTATE CENTRALIZED MAILING
(for New York City, Hempstead, Hauppauge & Peekskill Districts)
PO Box 5205 Binghamton, NY 13902-5205
NYC (800)877-1373 / Hemp. (866)805-3630 / Haup. (866)681-5354 / Peek. (866)746-0552

100 Broadway Menands ALBANY 12241 (866) 750-5157	State Office Building 44 Hawley Street BINGHAMTON 13901 (866) 802-3604	Statler Towers 107 Delaware Ave. BUFFALO 14202 (866) 211-0645	130 Main Street W. ROCHESTER 14614 (866) 211-0644	935 James St. SYRACUSE 13203 (866) 802-3730

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 and/or Date of Accident ☐WCB ☐DB ☐Discrimination

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 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

____, at
Name of a Specific Person, Corporation, Association or Public or Private Entity

____.
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.

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.

PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE
BENEFITS ASSIGNMENT

I here by authorize and direct my (Insurance Company):_______________________
To pay directly to:

1207 Route 9
Wappingers Falls, Ny 12590

If in the event my current policy prohibits direct payment to the doctor, then I hereby also authorize and direct you to pay directly to:

(Your Name):_______________________

1207 Route 9
Wappingers Falls, Ny 12590

This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner any balance of the said professional service charges over and above this insurance payment.

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

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

Date_______________

____
Signature of Policyholder

____
Witness

____
Signature of Claimant, if other than Policyholder

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

☐ Medical Record from (insert date) ________________ to (insert date) ________________

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: ______________________________

____

Include: (*Indicate by Initialing*)

________ **Alcohol/Drug Treatment**

________ **Mental Health Information**

________ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here ____________ I authorize ______________________________

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

______________________________ Date: ______________________

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use
of the HIPAA-compliant Authorization Form to
Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

PREGNANCY RELEASE

This is to certify that to the best of my knowledge, I am not pregnant and that the has my permission to take x-rays.

Last day of menstrual period:________________________________ .

Signed:___________________________________ Date:_______________________

Witness:__________________________________ Date:_______________________

CONSENT TO TREAT / EXAMINE MINOR CHILD

I hereby give my permission to the to examine and treat my child of ward.

Child's Name:________________________________

Signature:___________________________________ Date:____________________

Witness:_____________________________________

CONSENT TO X-RAY A MINOR CHILD

I hereby give my consent to the to x-ray my child.

Child's Name:________________________________

Signature:___________________________________ Date:____________________

Witness:_____________________________________

PATIENT UNDERSTANDING FOR OPIOID TREATMENT FORM

Patient Name________________________________

Witness Name ________________________________

I am taking a pain medicine called **OPIOIDS** to help improve my pain.
I agree (*patient must initial each line to show agreement):*

_____I will take my pain medicine exactly the way doctor tells me to. That means I will take the right amount of pain medicine at the right time.

_____I will tell my doctor about any new medical problems.

_____I will tell my doctor about all medicine I take, and will tell my doctor if I am given any new medicines.

_____I will tell my doctor if I see another doctor, or if I go to the Emergency Room.

_____I will only get my pain medicine prescription from this facility.

_____If my doctor is away, I will only get medicine from the doctor who is in charge while my doctor is away.

_____I will only get my pain medicine from one pharmacy (drug store).

_____I will follow my doctor's directions about therapy, exercises and physical things to do so I can learn to live with my pain.

_____I will do what I can to get back to work.

_____I will not drink alcohol or use any other drugs unless I am told to do it by my doctor.

_____When I am asked, I will get lab tests to see if I am taking my medicines the right way.

_____If the lab tests show that I am not taking the medicines the way I should, my doctor may cut down or stop my medicine or send me to a specialist or special program to help care for me.

_____I will store my pain medicine in a safe place where other people cannot take it.

_____I will keep my scheduled appointments. If I must miss an appointment, I will call my doctor to cancel at least 24 hours before the appointment.

_____I am not pregnant and I will call my doctor as soon as possible if I think I may be pregnant.

My doctor may stop giving me pain medicine if:

- I do not follow this agreement.
- The pain medicine is not helping me.
- I'm not meeting my goals in active therapy.
- My pain or my functions do not improve.
- I have bad side effects from the pain medicine.
- I become addicted to the pain medicine.
- I give or sell the pain medicine to someone else.

Patient Signature: ___________________________ Date:________________

I attest that this form was reviewed by me with the patient and all questions were answered.

Doctor Signature:___________________________ Date:________________

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

EFFECTIVE DATE: 9/19/2013

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

PATIENT INFORMED CONSENT FOR TREATMENT WITH OPIOIDS FORM

Patient Name______________________________

Witness Name______________________________

I plan to take a pain medicine called **OPIOIDS.** This pain medicine may help improve my pain but it may also cause some serious problems. The problems may be worse if I mix the pain medicine with alcohol or other drugs.

I understand that the pain medicine I will be taking may cause serious problems including:

⇨ Confusion.
⇨ Poor judgment.
⇨ Nausea (a stomach ache).
⇨ Vomiting.
⇨ Constipation (hard stools that may be painful to push out).
⇨ Sleepy or drowsy feeling.
⇨ Poor coordination and balance (such as feeling unsteady, tripping, and falling).
⇨ Slow reaction time.
⇨ Slow breathing or I can stop breathing - which could cause me to die.
⇨ More depression (such as feeling sad, hopeless, or unable to do anything).
⇨ Dry mouth.
⇨Increased feeling of pain (hyperalgesia).
⇨Addiction (it may be very hard to stop taking the pain medicine when I'm ready to quit).
⇨For men: the pain medicine may lead to less interest in sex and poor sexual performance.
⇨For pregnant women, the pain medicine may hurt my unborn child and may cause my child to be born addicted to the pain medicine.

I will tell my doctor if I have any of the problems listed here.
I understand there may be other problems caused by the pain medicine, in addition to the problems listed here.
I understand that these problems may get better when I stop taking the pain medicine.
My doctor has reviewed the serious problems that this pain medicine may cause. My doctor has answered all questions that I have about this pain medicine and the serious problems it may cause.

Patient Signature:________________________________ Date:_______________________
I attest that this form was reviewed by me with the patient and all questions were answered.
Doctor Signature:_________________________________ Date:_______________________

EFFECTIVE DATE: 9/19/2013

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

PLEASE BE ADVISED THAT OPEN TREATMENT AREAS ARE USED IN THIS OFFICE FOR PART OF YOUR CARE. PRIVATE TREATMENT AREAS ARE AVAILABLE UPON REQUEST.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

I acknowlegde receipt of a copy of P.C.'S **Notive of Privacy Practices.**

Signature of Patient:______________________________

Date:____________________ **EFFECTIVE DATE: 9/19/2013**

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, ______________________ (Claimant's Name), hereby authorize my treating health provider,

______________________ (Health Provider's Name), to disclose the following described health information:

____

____

____

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.