Workers Comp Welcome Packet **New Patient Form**

Thank you for choosing our facility and Welcome to Theradynamics!

If you have ever been a patient at any Theradynamics facilities, please notify a secretary

Patient Information:

Last Name: _____ First Name: _____

Date of Birth: _____/_____/_____ SSN#: _____ - _____ - _____ Gender: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Phone: Cell: (_____)_____ Home: (_____)_____ Work: (_____)_____

Marital Status: _____ Email Address: _____

Employment Status: ☐Full-Time ☐Part-Time ☐Retired ☐Unemployed ☐Student F/T ☐Student P/T

In Case of Emergency:

Contact Name: _____ Contact Number: _____ Relationship: _____

Primary Care Physician (PCP) Information:

PCP Name: _____ Phone: (____)_____ Fax: (____)_____

Referring Doctor Information: *if different from above*

MD's Name: _____ Phone: (____)_____ Fax: (____)_____

Insurance Information: *Please provide the secretary with a copy of all insurance cards upon 1st visit.*

Primary Insurance Provider: _____ Ins Telephone: (_____)_____

Insureds Name: _____ Insured DOB: ____/____/ _____ Insured SSN: _____-_____-_____

Relationship to Insured: _____ Policy ID#: _____ Group #: _____

Address (If different from above): _____

Employer: _____ Employer Address: _____

Primary Insurance Provider: _____ Ins Telephone: (_____)_____

Insureds Name: _____ Insured DOB: ____/____/ _____ Insured SSN: _____-_____-_____

Relationship to Insured: _____ Policy ID#: _____ Group #: _____

Address (If different from above): _____

Employer: _____ Employer Address: _____

theradynamics

Major Complaint:

Is your complaint a result of a WORK-related injury? ☐Yes ☐No

Is your complaint a result of a MOTOR-VEHICLE related injury? ☐Yes ☐No

Is your complaint a result of a PERSONAL injury? ☐Yes ☐No

When did your current conditional start? _____

Referral Information:

How did you hear about Theradynamics? Who referred you to us?

☐Hospital ☐Insurance ☐Instagram ☐Google ☐Facebook

☐Twitter ☐Self-Referred/Walk-In ☐Other: _____

☐Referring MD: _____

Allergies: *Please list all allergies to medications (both prescription and non) and other allergens (i.e. latex):*

_____

_____

_____

Medications You are Currently Taking:

Prescription Medications

Use the chart below to list all the brand-name and generic prescriptions you currently take. Be sure to fill in all the information for each medication. The amount of medication in each pill appears on the prescription label in milligrams (mg). This is called the dose, or strength. The label on liquids and shots lists the dose too.

Medication Name	Prescribing Doctor's Name	Reason for taking the medication	Dose (*example; 10mg, 50mg*)	How Often (*2x/day, 1x/ day*)

Non-Prescription Medications, Vitamins and/or Supplements

List all those that you take occasionally, such as aspirin for headaches, as well as those you take every day, such as multivitamins or nutritional supplements. Include and herds or alternative medicines that you take

Medication Name	Prescribing Doctor's Name	Reason for taking the medication	Dose (*example; 10mg, 50mg*)	How Often (*2x/day, 1x/ day*)

theradynamics

Appointment Reminder & Communication Consent

Last Name: _____ First Name: _____

Phone: Cell: (_____)_____ Email Address: _____

This form gives permission to provide automatic appointment reminders & communications by email or by cell phone text message.

☐May send email messages to confirm upcoming appointments, electronic bills/statements or other communication.

☐May send cell phone text messages to confirm upcoming appointments, electronic bills/statements or other communication.

I recognize that normal text messaging/date rates may apply.

Please indicate your Cell Phone Carrier:

We cannot set your account up to send email text message reminders without knowing your cell phone carrier. Please indicate you carrier information below, if you would like text message reminders:

☒ALL Tel	☐Metrocall	☐T-Mobile/Sprint	☐AT&T	☐Verizon
☐MetroPCS	☐US Cellular	☐Boost Mobile	☐Nextel	☐QWest
☐Virgin Mobile	☐Cricket Wireless	☐Other: _____		

_____ _____

theradynamics

Patient/Guardian Acknowledgement Signature	Date

MIPS FORM

MIPS QUALIFICATION – CLINIC FORM

Please answer each of the following questions and return the completed form to our clinical staff.

NAME: _____ **DATE OF BIRTH (**MM/DD/YYYY**): _____**

What are you/the patient being seen for?

- ☐ Neck of Upper Back (Neck Disability Index)
- ☐ Should or Upper Arm (Quick Dash)
- ☐ Elbow or Forearm (Quick Dash)
- ☐ Wrist or Hand (Quick Dash)
- ☐ Mid Back or Lower Back (Modified Oswestry Low Back Disability Questionnaire)
- ☐ Hip or Thigh (Lower Extremity Functional Scale)
- ☐ Knee (Knee Outcome Survey)
- ☐ Lower Leg (Lower Extremity Functional Scale)
- ☐ Ankle or Foot (Lower Extremity Functional Scale)

On/Around what date did you/the patient begin experiencing this issue?

(MM/DD/YYYY): _____

What is the Primary Payer for this episode?

- ☐ AUTO (Ex: Allstate, Farmers)
- ☐ COMMERCIAL (Ex: Blue Cross/Blue Shield/ Aetna)
- ☐ INDUSTRIAL (Ex: Worker's Comp.)

☐MEDICARE (Ex: Part B, Managed Medicare Plans)

☐MEDICAID (Ex: CHIP, Managed Medicaid Plans)

☐SELF PAY

(insert C-3 Form Here)

OFFICE POLICY INFORMATION

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE CARE. IF YOU HAVE MEDICAL INSURANCE, WE ARE EAGER TO HELP YOU RECEIVE YOUR MAXIMUM ALLOWABLE BENEFITS. IN ORDER TO ACHIEVE THESE GOALS, WE NEED YOUR ASSISTANCE, AND YOUR UNDERSTANDING OF OUR PAYMENT POLICY.

PAYMENTS FOR SERVICE ARE DUE AT THE TIME SERVICES ARE RENDERED UNLESS PAYMENT ARRANGEMENTS HAVE BEEN APPROVED IN ADVANCE BY OUR STAFF. YOU CAN CHECK WITH US FOR DIFFERENT FORMS OF PAYMENT WHICH ARE ACCEPTABLE. WE DO, AS A COURTESY TO OUR PATIENTS, VERIFY YOUR INSURANCE COVERAGE FOR YOU. ALTHOUGH WE WOULD LIKE TO ACCEPT ASSIGNMENT FROM ALL INSURANCE CARRIERS, YOU CAN CHECK WITH US TO SEE IF WE ACCEPT ASSIGNMENT UNDER YOUR SITUATION.

IF OUR OFFICE ACCEPTS ASSIGNMENT, WE WILL FILE YOUR INSURANCE CLAIMS FOR YOU. YOUR INSURANCE CARRIER WILL MAKE PAYMENT DIRECTLY TO THIS OFFICE. YOU ARE RESPONSIBLE FOR PAYING THE DEDUCTIBLE, COINSURANCE AND CO PAYMENT, IF ANY. PAYMENTS ARE DUE AT THE BEGINNING OF EACH VISIT. WE WILL GLADLY DISCUSS YOUR PROPOSED TREATMENT AND ANSWER ANY QUESTIONS RELATING TO YOUR INSURANCE

PLEASE NOTE - YOUR INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND THE INSURANCE CARRIER. WE ARE NOT A PARTY TO THAT CONTRACT.

1. OUR FEES ARE GENERALLY CONSIDERED TO FALL WITHIN THE ACCEPTABLE RANGE BY MOST CARRIERS, AND THEREFORE ARE COVERED UP TO THE MAXIMUM ALLOWANCE DETERMINED BY EACH CARRIER.THIS APPLIES ONLY TO CARRIERS WHO PAY A PERCENTAGE OF %50 TO % 80 OF U.C.R (USUAL, CUSTOMARY AND REASONABLE) FOR THIS REGION. THUS, OUR FEES ARE CONSIDERED U.C.R. BY MOST CARRIERS. THIS DOES NOT APPLY TO CARRIERS WHO REIMBURSE BASED ON AN ARBITRARY SCHEDULE OF FEES, WHICH BEARS NO RELATIONSHIP TO THE CURRENT STANDARD AND COST OF CARE IN THIS AREA.

2. NOT ALL SERVICES ARE A COVERED BENEFIT IN ALL CONTRACTS. SOME INSURANCE CARRIERS SELECT CERTAIN SERVICES THEY WILL NOT COVER. SINCE OUR RELATIONSHIP IS WITH YOU, NOT YOUR INSURANCE CARRIER, WE STRONGLY RECOMMEND YOU CONTACT YOUR INSURANCE CARRIER TO VERIFY THE COVERAGE YOU HAVE. INACCURATE INFORMATION GIVEN TO US YOU CONCERNING YOUR INSURANEC COVERAGE IS YOUR RESPONSIBILITY. WHILE FILING FOR INSURANCE CLAIMS IS A COURTESY WE EXTEND OUR PATIENT, ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE THE SERVICES ARE RENDERED. WE REALIZE THAT TEMPORARY FINANCIAL PROBLEMS MAY AFFECT TIMELY PAYMENT OF YOUR ACCOUNT. IF SUCH PROBLEMS ARISE, WE ENCOURAGE YOU TO CONTACT US PROMPTLY FOR ASSISTANCE IN THE MANAGEMENT OF YOUR ACCOUNT. RETURNED CHECKS AND BALANCES OLDER THAN 30 DAYS MAY BE SUBJECT TO ADDITIONAL COLLECTION FEES AND INTEREST CHARGES OF 15% PER MONTH (18% APR). CHARGES MAY ALSO BE MADE FOR BROKEN APPOINTMENTS AND APPOINTMENTS CANCELLED WITHOUT 24-HOURS ADVANCED NOTICE.

IF YOU HAVE ANY QUESTIONS ABOUT THIS INFORMATION OR UNCERTAINTY REGARDING INSURANCE COVERAGE, PLEASE DO NOT HESITATE TO ASK US. WE ARE HERE TO HELP!

_____ _____

Patient/Guardian Acknowledgement Signature Date

NOTICE OF PRIVACY PRACTICES / ACKNOWLEDGEMENT & CONSENT

I understand under the Health Insurance Portability & Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

___ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.

___ Obtain payment from third-party payers.

___ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read, received and understand this notice of privacy practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization may change its notice of privacy practices from time to time and I can call to obtain a copy of the current policy. I understand that I may request in writing that you restrict how my private information is utilized or disclosed to carry out my treatment. I also understand that you are not required to carry out my request. I have been given the right to review the above notice of privacy practices prior to signing this consent. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I authorize Theradynamics to use and disclose the protected health information described below to:

_____

(individual seeking the information)

Patient name: _____

_____ _____

Patient/Guardian Acknowledgement Signature Date

I attempted to obtain the patient's signature in acknowledgement of this notice but was unable to do so as documented below.

Reason: _____ Initials: _____ Date: _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

I hereby instruct and direct the _____ insurance company to pay by check made out and mailed directly to:

Theradynamics Rehab PT, OT & SLP, PLLC **Tax ID: 83-3078983**

280 West 231st St.

Bronx, NY 10463

If my current policy prohibits direct payment, then I hereby instruct and direct you to make the check payable to me and mail it as follows:

Name: _____ Address: _____

City/State/Zip Code: _____

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. 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 any balance of said professional service charges over and above this insurance payment. I understand the above has a financial interest, in any diagnostic testing. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

_____ _____ _____

Signature of the Policy Holder Signature of Claimant, If Other Than Policy Holder Date

INFORMED CONSENT

Physical / Occupational / Speech Therapy involves the use of many different types of physical evaluations and treatments. At this office, we use a variety of procedures and modalities to help us try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with these services.

Since the response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain modality or procedure. We are not able to guarantee what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury or may aggravate previously existing conditions.

You have the right to ask your clinician what type of treatment they are planning based upon your history, diagnosis, symptoms, and testing results. You may also discuss with your clinician what the potential risks and benefits of treatment might be. You have the right to decline any portion of your treatment at any time before or during a treatment session.

Therapeutic exercises are an integral part of your treatment plan. Exercise has inherent risks associated with it. If you have any questions regarding the type of exercises you are performing and any specific risks associated with your exercises, your clinician will be glad to answer them.

I acknowledge that my treatment program has been explained by my clinician, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of Physical/Occupational/Speech Therapy as outlined to me, and I wish to proceed.

_____ _____

Patient/Guardian Acknowledgement Signature Date

TELEHEALTH CONSENT

By signing this form, I understand and agree with the following:

Telehealth/Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists and/or subspecialists, nurse practitioners, registered nurses, medical assistants and other healthcare providers who are part of my clinical care team. In addition to myself and the members of my clinical care team, my family members, caregivers, or other legal representatives or guardians may join and participate in the telehealth/telemedicine service. I agree to share my personal information with such family members, caregivers, legal representatives, or guardians. The information may be used for diagnosis, therapy, follow-up and/or education.

I hereby consent to the use of telehealth/telemedicine in the provision of care and the above terms and conditions. By signing below, I certify that I am the legal representative of the participant or that I am the patient and am 18 years of age or older, or otherwise legally authorized to consent. I have carefully read and understood the above statements. I have had all my questions answered. I understand that this informed consent will become a part of my medical record.

_____ _____

Signature of Patient/Guardian Date

Printed Name of Patient/Guadian: _____

Relationship: _____

Date: _____

ASSIGNMENT, LIEN & AUTHORIZATION

I hereby authorize and direct you, my insurance company and/or my attorney to pay directly to Theradynamics any sums, as may be due or owed to Theradynamics for services rendered to me or my family

members for medical expenses arising from the accident in which I was injured and to withhold such sums from any settlement, judgement, or verdict on my behalf. This document is an assignment of my rights and benefits to the extent of the services provided by Theradynamics.

I hereby give a lien to Theradynamics against any and all insurance benefits named herein and all proceeds of settlement, judgement, or verdict that may be paid to me as a result of the injury or illness for which I have been treated by Theradynamics.

In the event that my insurance company, which is obligated to make payment to me for the charges made for services rendered by Theradynamics, refuses to make such payment; I hereby authorize Theradynamics to prosecute any arbitration or cause of action as my Assignee, towards settlement or other resolution towards this claim as they see fit.

I authorize Theradynamics to release any information pertinent to my or any insurance company, adjuster, or attorney to facilitate collections of this Assignment. I agree that Theradynamics has a special power of attorney to endorse/sign my name on any check/claim form in connection with this Assignment.

This assignment is to become effective as of the date indicated below and shall remain effective as long as services are being rendered to me or my family members related to this injury/illness. All third-party money owed to Theradynamics shall be paid in full. A photocopy of this Assignment shall be considered as effective and valid, as if it were the original.

I attest that the staff of Theradynamics has satisfactorily explained the terms of the Assignment to me, prior to the signing of this document. This document shall stand as my signature on file.

Patient Signature: _____ Date: _____

Patient Name: _____ Therapist: _____

Attorney Signature: _____ Date: _____

Name of Firm: _____

Address of Firm: _____

Contact #: _____

NEW YORK STATE OF OPPORTUNITY | Workers' Compensation Board

Employee Claim

State of New York - Workers' Compensation Board

C-3

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____ (First / MI / Last) 2. Date of Birth: _____/_____/_____

3. Mailing address: _____ (Number and Street/PO Box/Apartment No. / City / State / Zip Code)

4. Social Security Number: ___-___-_____ 5. Phone Number: (_____)_____ 6. Gender: ☐ M ☐ F ☐ X

7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (_____)_____

3. Your work address: _____ (Number and Street / City / State / Zip Code)

4. Date you were hired: _____/_____/_____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: _____/_____/_____ 2. Time of injury: _____ ☐ AM ☐ PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

YOUR NAME: _____ DATE OF INJURY/ILLNESS: _____/_____/_____
First MI Last

D. YOUR INJURY OR ILLNESS *continued*

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

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

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

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

E. RETURN TO WORK

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

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

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

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

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

Employee's Signature: _____ Print Name: _____ Date: _____/_____/_____

On behalf of Employee: _____ Print Name: _____ Date: _____/_____/_____

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

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

Signature of Attorney/Representative (if any): _____ Date: _____/_____/_____

Print Name: _____ Title: _____

ID No., if any: **R** _____ If Licensed Representative, License No.: _____ Expiration Date: _____/_____/_____

Instructions for Completing Employee Claim (Form C-3)

Please complete this form and send it to the Workers' Compensation Board centralized mailing address listed at the end of these instructions. If you need additional help completing this form, contact the Workers' Compensation Board at **1-877-632-4996.** You may also fill this form out online at **wcb.ny.gov**. If you do not have or know your Workers' Compensation Board Case Number, please leave this field blank. It is not required to process your claim. Remember to enter your name and the date of your injury/illness on the top of page two.

Section A - Your Information (Employee):

In Section A, enter your name, address and other requested information.
Note on Item 7: Board hearings are conducted in English. If you need a translator, select **Yes** and indicate the language needed.

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. § 552a).

The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

Section B - Your Employer(s):

In Section B, enter the name, address, phone number and other information of the employer you were working for at the time of the injury/illness.
Note: Your employer is the company or agency that issues your paycheck. If you are a contractor at a work site or office, the staffing agency or vendor who hired you is your employer, not the work site or office where you report to work.

Section C - Your Job on the Date of the Injury or Illness:

In Section C, enter your job title, work activities and pay information.

Section D - Your Injury or Illness:

In Section D, enter your injury or illness information.
Item 1: Enter the date you were injured or the first date you noticed you became ill.
If this is an illness or occupational disease, skip item 2. The date you were injured must be in month/day/year format. The year should be written as four digits, e.g., 2015.
Item 2: Enter the time when the injury occurred. Check whether it was AM or PM.
Item 3: Indicate the location where the injury/illness occurred, including the address of the building and the physical location in the building where the injury/illness happened.
Item 4: Check whether this was your normal work location. If it was not, explain why you were at this location.
Item 5: Describe in detail what you were doing at the time of the injury/illness (e.g., unloading boxes from a truck by hand). This explains the events leading up to the injury.
Item 6: Describe in detail how the injury/illness occurred (e.g., I was lifting a heavy box off a truck). This should include all people and events involved in the injury/illness.
Item 7: Indicate fully the nature and extent of your injury/illness, including all body parts injured. Be as specific as possible (e.g., I strained my back trying to lift a heavy box. It hurts to bend over or hold even lighter objects now).
Item 8: Indicate if some object was involved in the accident **other than** a licensed motor vehicle. Other objects may include a tool (e.g., hammer), a chemical (e.g., acid), machinery (e.g., forklift or drill press), etc.
Item 9: Indicate if a licensed motor vehicle was involved in the accident. If so, check if the motor vehicle involved was yours, your employer's, or a third party's. Include the license plate number (if known). If your vehicle was involved, fill out the name and address of your automobile liability insurance carrier.
Item 10: Check if you gave your employer or supervisor notice of your injury or illness. If so, indicate who you gave notice to as well as if it was orally or in writing. Include the date you gave notice.
Item 11: Check if anyone else saw the injury happen. If anyone did see it, include their name(s).

Section E - Return to Work:

Item 1: If you stopped working as a result of your work-related injury/illness, check Yes and indicate the date you stopped working. If you have not stopped working, check No and skip to the next section.
Item 2: If you have since returned to work, check Yes. Also indicate on what date you started working again, as well as if you have returned to your Normal Duties or if you are on Limited or Restricted Duty. (If you have not returned to your full pre-injury or illness work duties, then you are on Limited Duty.)
Item 3: If you have returned to work, indicate who you are working for now.
Item 4: Enter your gross pay (before tax pay) per pay period for the job you are working at now. Indicate how often you are receiving a paycheck (weekly, bi-weekly, etc.).

Section F - Medical Treatment for This Injury or Illness:

Item 1: If you did not receive medical treatment for this injury/illness, check None Received and skip to item 5. Otherwise, enter the date you first received treatment for this injury/illness and complete the rest of this section.
Item 2: Check if you were first treated on the job for this injury or illness.
Item 3: Check the location where you first received off site medical treatment for your injury or illness. Include the name and address of the facility as well as the phone number (including area code).
Item 4: If you are still receiving ongoing treatment for the same injury or illness, check Yes and indicate the name and address of the doctor(s) providing treatment as well as the phone number (including area code); otherwise, check No.
Item 5: If you already had an injury to the same body part or a similar illness, check Yes and indicate if you were treated by a doctor for this injury or illness. If you were treated by a doctor, indicate the name(s) and address(es) of the doctor(s) whom provided care and **complete and file Form C-3.3 together with this form.**
Item 6: If you had a previous injury or illness, check if your previous injury or illness was work-related. If Yes, check if the injury or illness happened while working for your current employer.

Sign Form C-3 in the place provided for Employee's Signature on page 2, print your name, and enter the date you signed the form. If a third-party is signing on behalf of the employee, that person should sign on the second signature line. If you have legal representation, your representative **must** complete and sign the attorney/representative's certification section on the bottom of page 2.

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 they are 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 carfares 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. Injured workers or dependents of deceased workers may represent themselves in matters before the Board or may retain an attorney or licensed representative to represent them. If an attorney or licensed representative is retained, their fee for legal services will be reviewed by the Board and if approved will be paid by the employer or insurance company out of any compensation benefits due. Injured workers or dependents of deceased workers should not directly pay anything to the attorney or licensed representative representing them in a compensation case.
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.

This form should be filed by sending directly to the address listed below:
New York State Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Toll-Free Number: 877-632-4996