Pain Management Center of Long Island

# Workers Compensation

## PATIENT WC DEMOGRAPHIC

**Do you have more than ONE accident?** ☐ YES ☐ NO **If YES, STOP and ask for additional required forms**

| | | | | | |
|---|---|---|---|---|---|
| **Patient Last Name** | **First Name** | **MI** | **Date of Birth** | **Age** | **Sex** |
| | | | | | |

| | | | |
|---|---|---|---|
| **Patient Address** | **City** | **State** | **Zip Code** | **Social Security #** |
| | | | | |

| | | | |
|---|---|---|---|
| Marital Status<br>☐ S ☐ M<br>☐ D ☐ W | Primary Language<br>☐ ENGLISH ☐ _____ | Race ☐ American Indian ☐ Asian<br>☐ Black ☐ Native Hawaiian<br>☐ Unknown ☐ White ☐ Decline Info | Ethnicity: ☐ Hispanic<br>☐ Non-Hispanic<br>☐ Type Unknown |

| | | | |
|---|---|---|---|
| Patient Telephone# | Patient Cell Phone # | Patient Work# | Email: |
| | | | |

| | | | |
|---|---|---|---|
| Emergency Contact | Relationship | Telephone # | Family Doctor Name & Phone: |
| | | | |

| | | |
|---|---|---|
| Primary Reason for Visit | Referred to us by: | Pharmacy Name and Address: |
| | | |

| | | | |
|---|---|---|---|
| **WC Insurance Carrier** | **WCB#** | **Date of Injury** | **Claim #** |
| | | | |

**Carrier Address**

**Adjuster Name:** **Phone #** **Fax #**

**How did Injury occur?**

| | | |
|---|---|---|
| **Employer at time of accident:** | **Body Parts covered:** | **Have you had any epidurals this year?** |
| | | |

| | | |
|---|---|---|
| **Is the case open / settled?** | **Are you Working?**<br>**Last Day Worked?** | **Any Judgments against the case?** |

**PLEASE HAVE PHOTO I.D. AVAILABLE. ADDITIONAL CASES, COMPLETE ANOTHER FORM.**

**We can share information with your:**

**Spouse:_____ Significant Other: _____ Parent: _____ Children: _____ PCP: _____ Attorney: _____ Other: _____**

☆ I have received a copy of my HIPAA Privacy Policy

☆ In the event that my Work Comp Insurance terminates, I agree to have my private insurance billed. Insurance: _____

ID# _____

**Patient Signature:** _____

Name:
DOB:
Date:

Pain Management Center of Long Island

## Comprehensive Pain Evaluation and History - Workers Compensation

Date : _____ Height: _____ Weight: _____ lbs. Blood Pressure: _____ Right/Left Handed

**ALLERGIES:** ☐ **No Known Drug Allergies**

| Allergic to: | Severity |
|---|---|
| _____ | ☐ mild ☐ moderate ☐ severe ☐ anaphylactic |
| _____ | ☐ mild ☐ moderate ☐ severe ☐ anaphylactic |
| _____ | ☐ mild ☐ moderate ☐ severe ☐ anaphylactic |
| _____ | ☐ mild ☐ moderate ☐ severe ☐ anaphylactic |
| _____ | ☐ mild ☐ moderate ☐ severe ☐ anaphylactic |

Please list all previous **SURGERIES:** _____

Do you have a family history of addiction or chronic pain? (specify) _____

**LIFESTYLE** (Current Smoking Status:)

☐ Never Smoker
☐ Former smoker ……
Year Started _____
Year Stopped _____

☐ Current Every Day Smoker….. Year started smoking _____ #Packs per day _____
☐ Current Some Day Smoker….. Year started smoking _____ #Packs per day _____
☐ Tobacco smoker __Heavy __ Light...Year started smoking ____ # Packs / Day ____

☯ **MEDICAL HISTORY: Do you or have you had: (check all that apply)**

☐ Asthma
☐ Arrhythmia
☐ Bipolar Disorder
☐ Blood Disorder
☐ Cancer: _____
☐ Cardiovascular Disease
☐ Cardiac Stents
☐ Depression
☐ Diabetes
☐ Heart Attack
☐ Hypertension
☐ Kidney Disease
☐ Liver Disease
☐ Migraines
☐ Peptic Ulcer Disease
☐ Seizures
☐ Sleep Apnea
☐ Stroke
☐ Thyroid Disease

**Mother's Medical History** ☐ No relevant history

**Father's Medical History** ☐ No relevant history

Please list all other **medical conditions** you have or are under treatment for? (Liste todas sus condiciones medicas)

☯ **What is the complaint which you are seeking help for**? (Cual es su dolor?)

☯ **Describe your Work Related Accident/Injury:**

☯ When did the pain begin? How long has it been present? (Cuando empezo su dolor y cuanto tiempo lo tiene?)

Name:
DOB:
Date:

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☯ Since it began how has the quality changed? e.g. Increased, decreased, unchanged. (Como ha cambiado su dolor? Tiene mas, menos, sin cambios desde el inicio del dolor)

☯ How often does the pain occur? **Circle ONE** (Con que frecuencia le ocurre su dolor? Marque Uno)

Non-Stop continuous Several times a day Occurs once a day several times weekly Several times a month

Seguido y constantement Varias veces diario Ocurre una vez diariamente semanal Ocurre varias veces mensual

☯ **For the following please use 0-10** (Del # 0 al 10, con diez siendo el dolor mas grave anote como le afecta su dolor?)

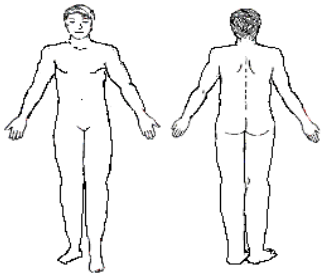
*0 = no pain disruption, 10 worst pain imaginable extremely disruptive*

Pain at its worse ever? Maximo Dolor _____

Pain at its best ever? Minimo Dolor _____

**Pain Score today (0 - 10):** _____

☯ Please shade in the affected areas (Marque las areas de su dolor)



☯ Which characteristics describe your pain? **Check all that apply**. (Marque las descripciones de su dolor)

| | | | |
|---|---|---|---|
| ☐ Aching (agotado) | ☐ Pins/Needles (hormigiante) | ☐ Soreness/Stiff (tiezo) | ☐ Other: |
| ☐ Burning (arde) | ☐ Radiates (dolor se extiende) | ☐ Stabbing (apunalado) | _____ |
| ☐ Cramping (calambres) | ☐ Sharp (dolor que pica) | ☐ Tender (tierno) | |
| ☐ Dull (dolor leve) | ☐ Shooting (dolor se dispara) | ☐ Throbbing (palpitante) | |
| ☐ Numbness (entumecido) | ☐ Spasm (calambre) | ☐ Tingling (dolor hormigiante) | |

☯ What makes the pain better? (Que le alivia su dolor?)

☯ What makes the pain worse? (Que le empeora su dolor?)

☯ What specialist have you seen for the pain? Chiropractor, Neurologist, Orthopedist, Physical Therapist, Surgeon ?
Que especialistas ha consultado para su dolor? Quiropractico, Neurologo, Ortopedista, Terapia Fisica, Cirujano ?

Date seen Physical therapist (Fechas que tuvo terapia fisica?) _____

Date seen Chiropractor (Fechas que tuvo tratamientos quiropracticos) _____

Date seen Other (Fechas de otros especialistas?) _____

Name:
DOB:
Date:

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☯ What therapies have you tried for the pain? Circle & write in others. Surgery , nerve blocks, brace, physical therapy, biofeedback, relaxation, TENS and Heat, injections, acupuncture, chiropractic, massage, hypnosis, ultrasound, etc.
(Que terapias le han hecho para su dolor? Marque todas y escriba si no estan listadas: Cirugia, inyecciones, terapia fisica, relajacion, maquina TENS, acupuntura, quiropractico, masajes, ultrasonido )

☯ What medicine do you currently take for your pain? Specify next to each who prescribes them to you and whether:
Helps, No-help or Not sure. Include over the counter, herbal and alternative preparations. (Que medicina esta tomando para su dolor? Especifique a lado de cada una si le ayuda. Incluya todas medicinas farmaceuticas y naturales)

☯ What other medication have you taken for pain? Why were they stopped? (Que otras medicinas ha tomado para su dolor? Porque las dejo de tomar?)

☯ Please list **all other medications** you are currently taking. Including over the counter herbal and alternative supplements.
(Liste todo tipo de medicamentos que esta tomando incluyendo vitaminas y hiebras naturales)

☯ Do you or have you used **illicit or un-prescribed drugs? If so, which ones**. (Usted usa drogas ilegales? Cuales)

☯ Do you share **drugs**? (Comparte sus drogas?)

☯ How much **alcohol** do you consume in a week? (Cuantas bebidas alcolicas toma semanal?)

☯ What is you **current employment status**? What type of work do/did you do? (Esta trabajando? Que tipo de trabajo hace?)

☯ Are you involved in any lawsuits ? (Tiene un caso legal ahorra contra alguien?)

☯ How much relief do you expect to obtain? _____ % Reduction in my pain. (Que porcentaje de alivio espera? _____ %)

**Physician Signature** **Date**

Name:
DOB:

**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. | CARRIER CASE NO. | DATE OF INJURY | NATURE OF INJURY/ 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 providers 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:** **Pain Management Center of Long Island / NAPPM**
**77 North Centre Avenue, Suite # 202, Rockville Centre, New York 11570**

**To the Claimant**

Worker's 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 it if turns out that such fees are not legally required to be paid by your employers 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 employers 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 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 Healthcare 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 claimants 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 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