Ohio | Bureau of Workers' Compensation

Notice to Change Physician of Record

The physician selected must be BWC certified or the injured worker will be responsible for payment.

Instructions for the injured worker
- Please complete all of Part I of the form.
- Sign in the space provided, and submit all copies to your managed care organization (MCO) to record your change of physician.

Part I

Injured worker's name	Date of injury	Claim number
Address		Phone number ( )
City	State	Nine-digit ZIP code

Please change my physician of record for the above listed claim as follows:

From physician		Provider number
Address		Phone number ( )
City	State	Nine-digit ZIP code
To physician		Provider number
Address		Phone number ( )
City	State	Nine-digit ZIP code

Reason for change

☐ Physician moved ☐ Physician no longer practicing ☐ I moved ☐ Physician is not a BWC-certified provider

☐ Physician terminated patient-provider relationship
Please explain: _____

☐ Dissatisfied with physician's treatment
Please explain: _____

☐ Other, please explain: _____

Have you been treated by the new physician for the condition(s) allowed in your claim? Yes☐ No☐ If yes give date of first treatment _____

Injured worker's signature	Date

Instructions for the MCO
- MCO to complete PART II.
- MCO must notify BWC via EDI (148) of change of physician within 24 hours of notification by the injured worker.
- Return signed copies per distribution listed below.

Part II

We have received and recorded your request for change of physician. You may bill only medical services and items related to the treatment of the allowed conditions and in accordance with the MCO medical-management guidelines to the MCO or the self-insured employer. The allowed conditions for this workers' compensation claim with corresponding ICD-9-CM codes are as follows: _____

MCO name	Phone number ( )
MCO case manager	Date

Distribution: White–MCO Claim file • Yellow–Injured worker • Pink–Requested physician • Goldenrod–Former physician

BWC-1128 (Rev. 9/3/1999)

C-23

Ohio | Bureau of Workers' Compensation

First Report of an Injury, Occupational Disease or Death

By signing this form, I:
- **Elect to only receive compensation and/or benefits that are provided for in this claim under Ohio workers' compensation laws;**
- **Waive and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury or occupational disease, or death resulting from an injury or occupational disease, for which I am filing this claim;**
- **Agree that I have not and will not file a claim in another state for the injury or occupational disease or death resulting from an injury or occupational disease for which I am filing this claim;**
- **Confirm that I have not received compensation and/or benefits under the workers' compensation laws of another state for this claim, and that I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.**

WARNING:
Any person who obtains compensation from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements or accepting compensation to which he or she is not entitled, is subject to felony criminal prosecution for fraud.
(R.C. 2913.48)

Injured worker and injury/disease/death info.

Last name, first name, middle initial		Social Security number	Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Date of birth
Home mailing address		Sex ☐ Male ☐ Female		Number of dependents
City	State / 9-digit ZIP code	Country if different from USA		Department name
Wage rate $ _____ Per: ☐ Hour ☐ Month ☐ Week ☐ Year ☐ Other _____		What days of the week do you usually work? ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat		Regular work hours From _____ To _____
Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers' Compensation? ☐ Yes ☐ No If yes, please explain.				Occupation or job title

Employer name

Mailing address (number and street, city or town, state, ZIP code and county)

Location, if different from mailing address

Was the place of accident or exposure on employer's premises? ☐ Yes ☐ No
(If no, give accident location, street address, city, state and ZIP code)

Date of injury/disease	Time of injury _____ ☐ a.m. ☐ p.m.	If fatal, give date of death	Time employee began work _____ ☐ a.m. ☐ p.m.	Date last worked	Date returned to work
Date hired	State where hired		Date employer notified	State where supervised	

Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death.)	Type of injury/disease and part(s) of body affected (For example: sprain of lower left back)

Benefit application release of information – I am applying for a claim under the Ohio Bureau of Workers' Compensation Act for work-related injuries that I did not inflict. I affirm that I elect to receive compensation and benefits under Ohio's workers' compensation laws for my claim, and I waive and release my right to file for and receive compensation and benefits under the laws of any other state for this claim. I request payment for compensation and/or medical benefits as allowable, and authorize direct payment to my medical providers. I permit and authorize any provider who attends, treats or examines me, the Ohio State Board of Pharmacy, the Ohio Department of Job and Family Services and the Ohio Rehabilitation Services Commission to release medical, psychological, psychiatric, pharmaceutical, vocational and social information. I understand this may include personally identifying information that is casually or historically related to my physical or mental injuries relevant to issues necessary for the administration of my claim to BWC, the Industrial Commission of Ohio, the employer in this claim, the employer's managed care organization and any authorized representatives. My previous or future BWC claims may affect decisions made in this claim. Proper administration of the present claim may require BWC to share claims information with the employers of record (or their authorized representatives) and/or my authorized representative for any and all such previous or future claims. The released claims information may include any record maintained in my claim files.

Injured worker signature	Date	E-mail address	Telephone number	Work number ( )

Treatment info.

Health-care provider name	Telephone number ( )	Fax number ( )	Initial treatment date
Street address	City	State	9-digit ZIP code

Diagnosis(es): Include ICD code(s)

Will the incident cause the injured worker to miss eight or more days of work? ☐ Yes ☐ No	Is the injury causally related to the industrial incident? ☐ Yes ☐ No	
E code	11-digit BWC provider number	Date

Health-care provider signature

Employer info.

Employer policy number	Check if ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm			
Telephone number ( )	Fax number ( )	E-mail address	Federal ID number	Manual number

Was employee treated in an emergency room? ☐ Yes ☐ No	Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No

If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code

☐ **Certification** - The employer certifies that the facts in this application are correct and valid.

☐ **Rejection** - The employer rejects the validity of this claim for the reason(s) listed below:

For self-insuring employers only
☐ **Clarification** - The employer clarifies and allows the claim for the condition(s) below:
☐ **Medical only** ☐ **Lost time**

Employer signature and title	Date	OSHA case number

Gillis Chiropractic Clinic

Worker's Compensation or Accidental Injury Questionnaire

Name: _____

Date of Accident: _____ Hour: AM / PM Location: _____

In what area did you feel pain immediately? _____

List the extent of injuries, as you know them: _____

Did you require post- accident care or hospitalization? Yes / No Date: _____

What treatment did you receive? _____

Treating physician: _____

Did you receive any cuts? Yes / No Locations: _____

Check the symptoms you have noticed since the accident:

___ Headache	___ Pins & Needles in Arm or Legs	___ Cold Hands or Feet
___ Neck Pain	___ Numbness in Toes	___ Shortness of Breath
___ Back Pain	___ Numbness in Fingers	___ Light Sensitivity
___ Tension	___ Ringing in Ears	___ Sleep Issues
___ Stiff Neck	___ Memory Loss	___ Nervousness
___ Dizziness	___ Loss of Balance	___ Irritability
___ Chest Pain	___ Loss of Smell	___ Depression
___ Fainting	___ Loss of Taste	___ Fatigue

Have you lost any days of work? Yes / No Dates: _____

Any previous surgeries: _____

Any previous related injuries: _____

Please give all details of how your accident occurred. Please use terms such as slip, twist or fall where applicable. Give weight of any objects, working conditions, etc: _____

_____

_____

_____

Did you report the injury to your employer? Yes / No

Name of person you reported injury: _____ Date/Time: _____

Gillis Chiropractic Clinic
PERSONAL HISTORY

Date:_____

Name:_____ Social Security #:_____

Address:_____City:_____State:_____Zip Code:_____

Home Phone:_____Cell Phone:_____Business Phone:_____

Birthdate:_____Age:_____Sex:_____Height/Weight:_____

Name of your Employer:_____Type of Work:_____

Type of Insurance:_____Marital Status:_____Name of Spouse:_____

Spouse's Employer:_____Spouse's Social Security #:_____

Type of Insurance:_____Are you covered by this insurance?:_____

Name and Phone Number of Nearest Relative (Outside of your Home):_____

Who is responsible for your bill? (circle): Insurance Workman's Compensation Medicaid Medicare Self Auto Insurance Other:_____

Referred by (circle): TV Yellow Pages Previous Patient Internet Facebook

Friend:_____ Other:_____

PAST HEALTH HISTORY

SURGERIES: (Spinal or joint) _____

_____

ACCIDENTS OR FALLS: (Please Describe) _____

_____

FRACTURES OR DISLOCATIONS:_____

_____

HABITS: Sleep (hours):_____ Coffee:_____ Alcohol:_____ Exercise:_____
Tea:_____ Tobacco:_____

Are you taking any medications? (Please explain for what):_____

_____

Are you Pregnant (circle): Yes No If yes, how far along:_____ Pacemaker (circle): Yes No

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Gillis Chiropractic to release any information including diagnosis and the records of any treatment or examination rendered to my child or me during the period of such chiropractic care to third payers and/or health practitioners. I authorize and request my insurance company to pay directly to Gillis Chiropractic or chiropractic group insurance benefits otherwise payable to me. A fee schedule is available upon request. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents.

_____ _____
Patient Signature Date

Name_____ Date of Birth_____ Date_____

WHEN DID SYMPTOMS APPEAR?_____

WAS THIS WORK OR AUTO RELATED?_____

HOW DID SYMPTOMS OCCUR?_____

_____

_____

SYMPTOMS

Please Circle All the Following Symptoms you have NOW.

	Side	Pain 1-10		Side	Pain 1-10	
Headaches			Pins/Needles in legs, feet, toes	R / L		Sinus Trouble
Neck Pain	R / L		Numbness in legs, feet, toes	R / L		Difficult Breathing
Stiff Neck	R / L		Pain in legs, feet, toes	R / L		Asthma
Fainting/Dizziness			Chest pain	R / L		Previous heart attack
Pins/Needles in arms, hands, fingers	R / L		High Blood Pressure/ Low Blood Pressure			Joint Swelling
Numbness in arms, hands, fingers	R / L		Pain between shoulder blades	R / L		Stomach Pain
Pain in arms, hands, fingers	R / L		Shoulder Pain	R / L		Bowel Changes
Mid Back Pain	R / L		Elbow Pain	R / L		Bladder Changes
Low Back Pain	R / L		Foot/Ankle Pain	R / L		Epilepsy
Hip Pain	R / L		Spinal Curve/ Scoliosis			Cancer

Other_____

Type of Pain (Circle): Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling Other

What aggravates your symptoms?_____

What gives you relief of your symptoms?_____

Are you presently being treated for any other condition? Yes No If yes, what?_____ _____ By who?_____

Have you ever had prior Chiropractic Care? Yes No If yes, who?_____

(For Doctor's Use Only)
ONSET:_____ ETIOLOGY:_____

HX OF BP:_____ PRIOR TX:_____

FAMILY CHIROPRACTIC CARE CENTER, INC
Dba Gillis Chiropractic Clinic

INFORMED CONSENT- CHIROPRACTIC OFFICE

Patient Name:_____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment: The primary treatment we use as a Doctor of Chiropractic is spinal manipulation therapy. We will use that procedure to treat you. The doctor may use his hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment: In addition to spinal manipulation, we may use a variety of other therapies and examination procedures. As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

Spinal manipulative therapy	Activator instrument spinal/extremity adjustment	palpation
Orthopedic testing	range of motion testing	vital signs
Basic neurological exam	muscle strength testing	hot/cold therapy
Postural analysis testing	x-ray/radiographic studies	electrical stimulation
Rehabilitation/core strengthening	manual traction adjustment	ultrasound
Cold laser therapy	spinal segmental traction	trigger point therapy

The material risks inherent in chiropractic adjustment. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation (CMT) and therapy. However studies have shown that any observed association between vertebral artery dissection (VAD) and stroke with CMT is likely attributed to patients with an undiagnosed VAD who seek care for neck pain and headache before the onset of a stroke.(i) As a result we examine our patients thoroughly before initiating any treatment to be sure that treatment is appropriate. The doctor, will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform the doctor.

The probability of those risks occurring. Chiropractic is a safe and comfortable form of health care for most people. If a potential risk is indentified, you will be informed and offered either treatment or a referral to the appropriate health care specialist for evaluation and care.

Soreness: It is not uncommon to experience some localized soreness following a manipulation. This type of soreness is usually minor and occurs most often following the initial few visits. It is similar to the soreness you experience after exercise.

Fracture: Fractures caused from spinal manipulation are extremely rare, so rare that an actual number of incidences per manipulation have never been determined. Patients suffering from bone weakening conditions like Osteoporosis are in a higher risk category. Alternative forms of spinal manipulation are utilized for this type of patient.

TIA/Stroke Overview: Spinal manipulation is clearly one of the safest forms of treatment for cervical spine pain. The incidence of serious events, strokes, or death is very rare.(ii) **Researchers found no evidence of excess risk of VBA stroke associated chiropractic care compared to primary care.**(iii) The risk was a low as 1.46 adverse events per 10,000,000 manipulations.(iv) The risk of artery dissection was a low as 1 per 5,846,381 cervical manipulations(v)

What about NSAIDS and Tylenol: To put it in perspective, non steroidal anti-inflammatory drugs (NSAIDS) kill approximately 16,500 people per year annually in the US.(vi) And Tylenol toxicity is now the leading cause of liver failure in the US.(vii,viii) Spinal manipulations is safer than NSAIDS by a factor of several hundred times. (ix)

Note: Screening tests are performed when necessary to rule out high risk patients. Alternative spinal adjusting is utilized when necessary to minimize potential risks.

Ruptured/Herniated Disc: There have been some reports of herniated or ruptured discs caused by spinal manipulation. Alternative spinal adjusting methods are often utilized to minimize the risk and help the patient recover from serious disc-related pain.

Other complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The availability and nature of other treatment options:

Other treatment options for your condition may include:
Self administered, over-the-counter may include:
Medical care and prescriptions drugs such as anti-flammatory, muscle relaxants and pain killers
Hospitalization
Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated or undertreated. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. Early intervention to restore normal function and compliance with the treatment program are both essential in an effort to prevent the condition from progressing to a chronic pain state. (x,xi,xii,xiii,xiv,xv)

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
I have read the above explanation of the chiropractic adjustment and related treatment. I will discuss it with Dr. Gillis, if I have any questions regarding the above information. **By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.**

Patient Name:_____

Patient Signature:_____ **Date**_____

Signature of Doctor:_____ **Date**_____

PATIENT TREATMENT CONSENT FORM

I authorize Gillis Chiropractic to release any medical or other information that may be necessary to process medical claims on my behalf to related physicians, rehabilitation counselors, social workers, insurance carriers or attorneys.
I authorize Gillis Chiropractic to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Financial Responsibility / Assignment of Benefits

I understand that I am responsible for paying my co-payments and deductibles at the time of service. I also understand that I am responsible for any balance due after payment by my insurance company.

I, the undersigned, understand that Gillis Chiropractic will bill my insurance company for services rendered upon verification of coverage by my insurance company. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for medical care and services rendered. If your insurance company does not remit payment within 60 days, the balance will be due in full from you.

I hereby request that my insurance carrier make payment directly to Gillis Chiropractic for all services rendered by this facility. If my current policy prohibits direct payment to Gillis Chiropractic, I hereby instruct and direct my insurance company to make the check out in my name but send the check to the listed address of Family Chiropractic Care Center, Inc. 1905 Lathem Ave. Lima, OH 45805.

If my insurance carrier makes a payment to me, I agree to immediately pay over these funds to Gillis Chiropractic. I also authorize Gillis Chiropractic to deposit checks received on my account when made out to me.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Charges related to Worker's Compensation injury shall be forwarded to the Worker's Compensation Insurance carrier. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you will be held responsible for the total amount of charges for services rendered to you.

Charges related to Personal Injury shall be forwarded to my attorney, or my car insurance carrier for payment. However, be advised that if your Personal Injury Claim is denied, you will be held responsible. I direct all payments from my insurance carrier/attorney to pay directly to Gillis Chiropractic for services rendered. Upon settlement of my personal injury claim, Gillis Chiropractic will be paid, or I assume all responsibility on my account.

I, the undersigned, acknowledge that by signing this form I authorize Gillis Chiropractic to submit charges via mail or internet to my insurance carrier. This is a "Signature on File" authorization.

Patient recognizes that Policy quotes are not a guarantee of payment by carrier and the patient is responsible for obtaining actual Policy benefits, limits from the carrier and, if needed, any referrals from primary care physicians or pre-authorization with insurance. All referrals or recommendations from our office have no confirmation of payment or benefits to referring providers.

I authorize my healthcare provider and/or entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by any telephone number, email address and/or mailing address provided. I authorize all my numbers that I have provided to the office in my file be able to accept phone and/or text message. I authorize stating a detailed message to all phone numbers that I have given Gillis Chiropractic.

List of prices (subject to change):
Chiropractic Adjustment: $40.00, $45.00
Examinations: $30.00, $55.00, $75.00
Therapy: $15.00-$20.00/each, Decompression $30.00
X-rays: $40-$105 each
Forms/Copies: $5.00-$20.00
Supports/Brace: Prices Vary

Acknowledgement of Receipt of Notice of Privacy Practices / Patient Consent

I certify that I was offered a copy of Gillis Chiropractic's Notice of Privacy Practices. The Notice of Privacy Practices describes the types and uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Gillis Chiropractic's health care operations. The Notice of Privacy Practices is also posted in the reception area.

Gillis Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requested a revised copy be sent in the mail or asking for one at the time of my next appointment.

I, the undersigned, state that I have read all the above and agree to the terms and conditions set forth.

Patient Name/Date

Patient/Guardian Signature/Date