WORKERS' COMPENSATION QUESTIONNAIRE

Name: Date:

Employer: Address:
(At the time of the accident)

ACCIDENT INFORMATION

Details of how accident happened:

Job description/duties at the time for the accident:

Date & Time of Accident: Name of person/s notified:
Date Notified: Job Title:

* Does your job involve repetitious movement? Y N

Does your job involve lifting? Y N How many pounds? _____ (approximate)
Must you carry this weight? Y N How far? _____ (approximate)
* Do you feel this injury affects your ability to perform any job related duties? Y N

How did you feel immediately after accident?

Exact area(s) of pain following accident:

* Was any treatment given? Y N

Name and Location of doctor, if any:
* After the accident, did you return to work? Y N

Since the accident, are symptoms ( ) improving ( ) same ( ) worse Please explain:

* Are there any positions, which allow you to perform your work more easily? Y N

* Any previous injuries or symptoms to the same area? Y N

* Have you had a previous Workers' Compensation claim? Y N (If Yes) Date/s of accident/s and nature of the injury/s

* Do you have any other conditions that affect your work? Y N

Do you feel your condition is ( ) temporary ( ) permanent ? Please explain

Signed: Date:

- Y – Yes answer – please explain

WORKERS' COMPENSATION BOARD

Employee Claim

C-3

State of New York - Workers' Compensation Board

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 / City / State / Zip Code)

4. Social Security Number: ___ - ___ - _____ 5. Phone Number: (___)_____ 6. Gender: ☐ Male ☐ Female

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: _____ (First / MI / Last) DATE OF INJURY/ILLNESS: ____/____/____

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. Do you remember having 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 he or she is 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: ____/____/____

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF *FAILURE TO PROSECUTE*, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)	CLAIM ADMIN CLAIM NUMBER (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	CLAIMANT'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS	APT. NO.
EMPLOYER			
INSURANCE CARRIER			

You may become responsible for the medical costs of treatment for your illness or condition with the health care provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation insurer/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature_____ Date _____

Provider's Name and Address Dr. Sam Vassallo, Family Chiropractic Care. 24304 NYS RT 37 Watertown, NY 13601

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your health care provider to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or insurer may not be required to pay the provider's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of their bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with their employer or its insurance carrier settling their case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or insurer of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of their bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that they may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the insurer of liability for medical treatment is approved.

PERSONAL FINANCIAL AND INSURANCE INFORMATION

NOTE: A COPY OF YOUR INSURANCE CARD(S) WILL BE MADE FOR YOUR FILE.

PATIENT INFO: TODAY'S DATE:_____

PATIENT NAME:_____ ___Male ___Female

PARENT /LEGAL GUARDIAN (if patient is a child)_____

MAILING ADDRESS:_____
Street Address, City, State, Zip

EMAIL ADDRESS:_____PHONE:_____CELL:_____

SOCIAL SECURITY # _____DATE OF BIRTH: _____

EMPLOYER:_____ADDRESS_____PHONE_____

PRIMARY INSURANCE INFO:

INSURANCE CARRIER_____ID #_____

PRIMARY HOLDER: _____ ___Male ___Female

RELATIONSHIP TO PATIENT: (circle one) Self Spouse Parent Other_____

ADDRESS:_____
Street Address, City, State, Zip

PHONE NUMBER: _____ DATE OF BIRTH: _____

SECONDARY INSURANCE INFO: (if any)

INSURANCE CARRIER:_____ID#_____

PRIMARY HOLDER: _____ ___Male ___Female

ADDRESS: _____
Street Address, City, State, Zip

PHONE NUMBER: _____ DATE OF BIRTH: _____

Patients or Authorized Individuals Signature

I authorize the release of any medical information necessary to process this claim.

Signed: _____ Date: _____

I authorize direct payment of medical benefits to **FAMILY CHIROPRACTIC CARE, P.C., DR. MANDY K. VASSALLO, D.C. or Dr. SAM VASSALLO, D.C.** as applicable.

Signed: _____ Date: _____

If your insurance has a copayment you are responsible for payment before treatment is rendered. The contract you have with your carrier requires payment at the time of service; therefore payment cannot be waived. You are responsible for any co-insurance, deductibles, or non-covered services not paid by your insurance.

Signed:_____Date:_____

Medicare Patients Only

Medicare will consider covering Chiropractic Treatments ONLY after your deductible has been met. Examinations are not applied to your deductible amount. Under most instances, Medicare will cover 80% of each office visit up to twelve (12) per year. Any charges for visits in excess of twelve (12) per year, examinations, x-rays or additional therapy ordered are the responsibility of the patient.

Signed: _____ Date: _____

Chiropractic Informed Consent

For your information the following is furnished to all patients who request and/or accept chiropractic care in this clinic. Again, chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions. This clinic is staffed with graduate chiropractors who are licensed and recognized by government agencies regulating all the aforementioned healing arts.

You should understand the benefits of chiropractic health care, but you also need to be aware of come of the limited inherent risks. These occur seldom enough to contraindicate care, but should be considered in your informed decision to receive chiropractic care.

Appropriate tests will be performed to identify if you may be susceptible to these risks, and you will be notified, in that case. If you have any questions about these issues, please do not hesitate to speak with your doctor of chiropractic. If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I request and consent to the performances of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical mylopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do expect the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the risks are not guaranteed.

I have read (or have had read to me) the above information. I wish to rely on the doctor's judgment during my course of care, based on the facts then known I have also had opportunity to ask questions regarding the above information and possible consequences and risks. By signing below, I now agree to have the chiropractic care procedures recommended and performed. I have no questions, and I acknowledge no guarantee of cure has been made to me concerning results, care and treatment.

Print Name:_____

Signature:_____ Date:_____

Consent of Disclosure

I herby give consent to Family Chiropractic Care, P.C. and all health care providers furnishing care within Family Chiropractic Care, P.C. to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that others or we have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment or health operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

We reserve the right to amend the terms of our Posted Privacy Policy.

Print Name:_____

Signature:_____Date:_____
If you are signing as a patient's representative:
Print your name:_____

Relationship:_____

Cancellation

I hereby void the consent given above.

Print Name:_____

Signature:_____Date:_____
If you are signing as a patient's representative:
Print your name:_____

Relationship:_____

Address for cancellation: Your cancellation will be effective, upon receipt at the following address:

Family Chiropractic Care, P.C.
24304 NYS Rt. 37
Watertown NY 13601

Family Chiropractic Care, PC

Financial Policy

Welcome to Family Chiropractic Care P.C. As one of our patients, we feel it is important to advise you of FCC financial policy.

Insurance: Please bring your insurance card with you at each appointment. We cannot obtain your insurance information or bill for your services unless we have your health insurance information. Failure to present your insurance card could result in your visit being rescheduled.

If your insurance has a copayment you are responsible for payment before treatment is rendered. The contract you have with your carrier requires payment at the time of service; therefore payment cannot be waived. You are responsible for any co-insurance, deductibles, or non-covered services not paid by your insurance.

Referrals: If your insurance requires an authorization or referral it is the responsibility of the patient/parent to obtain this information from your primary care physician (PCP) before your appointment. FCC reserves the right to reschedule your appointment without this information.

Payment Methods: FCC will accept payments by the following methods: Cash, check, Visa, MasterCard. Discover and debit cards. FCC will also accept debit/credit for patients/parents with flexible spending or health savings accounts.

Medical Records: FCC will mail or fax a copy of all or a portion of your medical records once a request is received in writing. Records more than 5 pages are subject to a fee of $.75 per page as allowed under the Public Health Law. If you wish for your records to be mailed, there may be an additional fee to cover the mailing cost. Any person picking up records will need to sign a letter of release and show proof of identity.

Financial Charges: A $30.00 charge will be added to your account for any check returned by your bank for any reason. In the event your account is turned over to a Collection agency you may also be liable for attorneys' fees and court cost.

Non-compliance: This is an agreement between FCC as the provider of service and creditor, and patient/debtor named on this form. I have read and understand this policy and all my questions have been answered to my satisfaction.

_____ _____

Patient/Parent/Guardian Date

_____

Please Print

Patient Health Questionnaire

Name:_____ Date:_____

1. When did your symptoms start?_____ Describe your symptoms and how they began:

_____

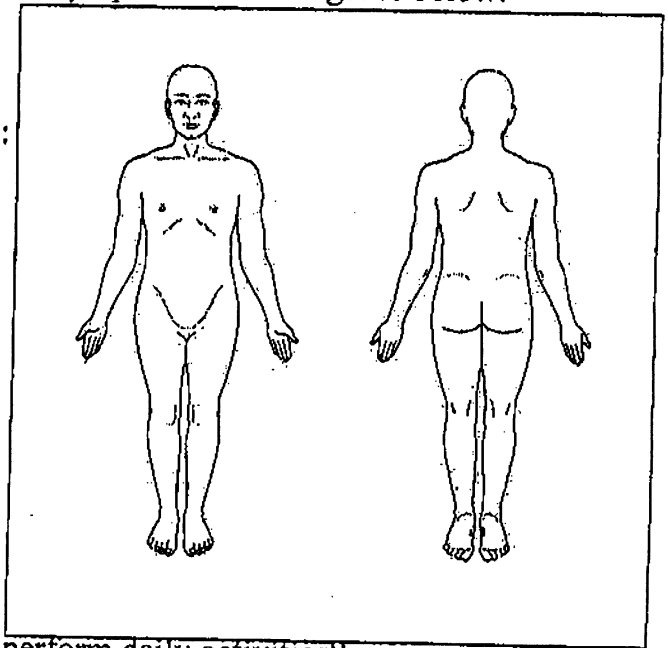
_____

2. Symptoms are:

____Occasional ____Frequent

____Constant ____No Pain

Indicate where you have pain or other symptoms on the figures below:



3. What describes the nature of your symptoms:

____Sharp ____Numb

____Burning ____Dull ache

____Shooting ____Tingling

4. How are your symptoms changing?

____Getting Better

____Not Changing

____Getting Worse

5. How do your symptoms affect your ability to perform daily activities?_____

_____

6. What activities make your symptoms worse?_____
7. What activities make your symptoms better?_____
8. What at-home care have you tried?_____
9. How does your condition affect your sleep?_____
10. Who have you seen for this particular onset of your condition?

( ) No One ( )Other Chiropractor ( )Medical Doctor ( )Physical Therapist

a. When and what treatment?_____

b. What tests have you had for your condition and when were they performed?

( ) Xrays Date:_____ ( )MRI Date:_____ ( )CT Scan Date:_____

11. If you have had similar symptoms in the past what did you do to obtain relief?

_____

12. What is your occupation?_____
13. Do you have a medical doctor you normally see?_____
14. Have you seen a chiropractor before? ___Yes ___No Who?_____
15. Have you had any previous falls, traumas, car accidents or work accidents? Explain:

_____

_____

Family Chiropractic Care
Patient Health Questionnaire

Patient Name: _____ Date: _____

What type of regular exercise do you perform? ____None ____Light____Moderate____Strenuous

What are your overall health goals? ___Weight loss ___More Energy ___Healthy Aging
___Increased Performance ___Enhanced Mental Clarity ___Decrease Stress ___Eliminate Bad Habits
___Improve Lifestyle ___Other_____

For each of the conditions listed below, place a check in the past column if you have had the condition in the past. If presently have a condition listed below, place a check in the present column.

Past	Present	
___	___	Headaches
___	___	Neck Pain
___	___	Upper Back Pain
___	___	Mid Back Pain
___	___	Low Back Pain
___	___	Shoulder Pain
___	___	Elbow Pain
___	___	Elbow/Upper Arm Pain
___	___	Wrist Pain
___	___	Hand Pain
___	___	Hip/Upper Leg Pain
___	___	Knee/Lower Leg Pain
___	___	Ankle/Foot Pain
___	___	Jaw Pain
___	___	Joint Swelling/Stiffness
___	___	Arthritis
___	___	Rheumatoid Arthritis
___	___	General Fatigue
___	___	Muscular Incoordination
___	___	Visual Disturbances
___	___	Dizziness

Past	Present	
___	___	High Blood Pressure
___	___	Heart Attack
___	___	Chest Pains
___	___	Stroke
___	___	Angina
___	___	Kidney Stones
___	___	Kidney Disorders
___	___	Bladder Infection
___	___	Painful Urination
___	___	Loss of Bladder Control
___	___	Prostate Problems
___	___	Abnormal Weight Gain/Loss
___	___	Loss of Appetite
___	___	Abdominal Pain
___	___	Ulcer
___	___	Hepatitis
___	___	Liver/Gall Bladder Disorder
___	___	Cancer
___	___	Tumor
___	___	Asthma
___	___	Chronic Sinusitis

Past	Present	
___	___	Diabetes
___	___	Excessive Thirst
___	___	Frequent Urination
___	___	Smoking/Tobacco Use
___	___	Drug/Alcohol Dependence
___	___	Allergies
___	___	Depression
___	___	Systemic Lupus
___	___	Epilepsy
___	___	Dermatitis/Eczema/Rash
___	___	HIV/AIDS

Females Only

___	___	Birth Control
___	___	Hormonal Replacement
___	___	Pregnancy

Other Health Problems/Issues

_____

_____

Indicate if an immediate family member has had any of the following:
____Rheumatoid Arthritis____Heart Problems____Diabetes____Cancer____Lupus

List all prescription and over-the-counter medications and supplements:

_____

List all surgical procedures you have had and times you have been hospitalized:

_____

Patient Signature _____ Date_____

Spinal Decompression Table

Name: _____ Date_____

Spinal Decompression provides relief to severe back and neck pain sufferers and improves mobility in healthy spines by gently reducing the pressure within spinal discs. The state-of-the-art Non-Surgical Decompression Traction System utilizes a smooth method of cycling the spine through a series of slow pulls, holds and releases.
On average patients feel relief in as little as 6-10 sessions. Sessions last 15 minutes and should be repeated 1-2 times each week for maximum benefits.
As with any type of therapy, there is risk involved, however, the minimal risk that is involved with this therapy far outweighs the benefits. Studies show on average, you can expect one of the following during and after your treatments:

- 1% report a slight increase in pain
- 7% report no change in pain levels but an increase in spinal mobility.
- 92% report an improvement in pain and an increase in the range of motion of the spine.

This therapy is covered by some insurances.

Cash patients whose insurances do not cover are responsible for the cost of this therapy.

Prices for Spinal Decompression

$55 each

Buy 5 get one free ($275)

Buy 10 get 3 free ($550)

Buy 15 Get 5 free ($825)

By signing below, I acknowledge that I have read and understand the above information regarding Spinal Decompression.

Sign_____ **Date** _____