Carmel Medical Care, PC
91 Gleneida Ave; Carmel, NY 10512
P: (845) 228-7000 F: (845) 228-5485
TAX ID # 81-1931257
providers@advancedhealthny.com

Attention All Workers Compensation Patients:

Welcome to Carmel Medical Care, PC and Advanced Health NY. Please be advised that New York State has come out with treatment guidelines for your specific injury type. Your treatment in this office must follow these guidelines. We have carefully developed a treatment plan that allows treatment to be given three (3) times per week, for up to four (4) months if necessary for your injury.

Under these guidelines, you are required to attend at least 75% of your scheduled appointments. You are also required to participate in active care (i.e. rehabilitative exercise program) and make a reasonable effort to return to work. If you do not follow all of these requirements, you will be deemed as being outside the guidelines by the New York State Workers Compensation Board and payment for your treatment will be denied and we will be forced to release you from care.

Please sign below indicating that you have read, understand and will abide by these requirements:

Patient Name: _____

Patient Signature: _____

Date: _____

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Dear Patient:

Welcome to Carmel Medical Care, PC and Advanced Health NY. It is our pleasure to serve your health care needs. This office is a multi-disciplinary medical clinic which employs the talents of medical physicians, physician assistants, physical therapists, chiropractors, massage therapists and physical trainers. During your treatment you will receive care from all members of our team. We work together so our patients receive the most complete and comprehensive treatment available. In order for these treatments to be covered by your insurance, some procedures or modalities may be billed under the physician, the physical therapist and/or the chiropractor, or everything may be billed under one provider. This is dependent on state and federal regulations, insurance company policies and your particular plan.

Our providers are participating in most insurance plans, but not all, so you may have a portion of treatment that will be billed as an out of network provider.

This office uses the American Medical Association's CPT codes for billing all procedures performed in this office. Our fees are either taken directly from the Ingenix custom fee analyzer for this area of the country or are set by your insurance company.

If you have any questions or concerns about any of this, please ask and someone will go over it with you in detail.

I, the undersigned, have read and understand the above information and agree to these terms:

Patient Signature: _____

Date: _____

Patient's Guardian Signature: _____

Date: _____

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Confidential Patient Information

How did you hear about our office: _____

Patient Name: _____ Social Security #:_____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____ Home Phone: _____

Cell Phone: _____ Wok Phone: _____ Marital Status: _____

Occupation: _____ Employer: _____

E-mail: _____Nearest living relative & Phone # _____

Spouse Name: _____ Spouse work #: _____

Preferred Language: _____ Race: □ Native American or Alaskan Native □ Asian □ African American □ Hispanic or Latino □ Native Hawaiian or Pacific Islander □ Not Provided □ White

Smoking Status: □ 1-Current every day smoker □ 2-Current some days smoker □ 3-Former smoker □ 4-Never smoked □ 5-Smoker status unknown □ 9-Unknown if ever smoked

Reason For Treatment: Please Answer All Questions. Insurance Companies Require for Authorization For Treatment.

Main Complaint: _____

Additional Complaints: _____

When Did It Start: _____

What Brought It On: □ Auto Accident □ Work Injury □ Yard Work □ Household Chores □ Sports Injury □ Lifting Something □ A Fall □ Exercising □ Shoveling Snow □ Slept Wrong □ No Specific Reason □ Other Please specify: _____

What Makes It Worse: □ Work □ Sleeping □ Lying Down □ Sitting □ Driving □ Household Chores □ Yard Work □ Lifting □ Exercising □ Walking □ Taking Care Of Children □ Increased Activity □ Other Please Specify: _____

What Makes It Better: □ Sitting □ Lying Down □ Sleeping □ Resting □ Exercise □ Shower □ Heat □ Ice □Increased Activity □ Stretching □ Nothing □ Other Please Specify: _____

(PLEASE TURN OVER)

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Current Medications: _____

Other Doctors You Are Seeing For This Problem: _____

Current Treatments: _____

Have You Had A Similar Condition In The Past? _____ How Long Ago? _____

How Was It Treated: _____

Who Is Your Primary Care Physician? Name _____ Phone: _____

Allergies:_____

Please List Any Major Health Problems:_____

Is This Due To An Auto or Work Related Injury? _____ Has A Claim Been Filed? _____

Health Insurance Co.: _____ Policy_____ Primary Insured: _____

Authorization of Payment: I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand and agree that this office will prepare any necessary paperwork to assist me in making collection from the responsible insurance carrier and that any amount authorized to be paid directly to this office, will be credited to my account upon receipt of payment. However, I also understand and agree that all serviced rendered to me are charged directly to me and that I am personally responsible for payment for those services in full. I also understand that if I suspend or discontinue my care for any reason, any fees for services rendered are due and payable immediately. I also agree to assist this office in any way necessary, in collecting any payments due for services rendered to me by this office, from the responsible insurance carrier.

Consent to Treatment: I consent to Medical Care, Physical Therapy, Chiropractic, Massage Therapy, Rehabilitations and related services at this facility. In doing so, I understand, acknowledge and affirm that such services may involve bodily contact, touching and/or direct contact of a sensitive nature. I also understand, acknowledge and affirm that on a rare occasion these services may lead to a temporary increase in pain or soreness and on an even more rare occasion a more serious injury may occur in patients compromised with certain concomitant disease or illness. This includes the 1 in 1 million to 1 in 40 million chance of cerebral vascular accidents during manipulation or mobilization of the neck, the same probability of this occurring while turning your neck or having your hair washed at a salon. This is generally attributed to an underlying defect in the vertebral or basilar artery.

Treatment of Minors: I, as a parent or guardian of a minor receiving treatment, do hereby agree and understand that I have been advised to remain on the premises during any such treatment and waive any claim I may have resulting from failure to do so.

Waiver and Release: I hereby release, discharge, and acquit this facility, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action or loss of any kind arising from my refusal to accept, receive or allow emergency and/or medical services, included but not limited to ambulance service, EMT, physician or urgent care service.

By signing below, I acknowledge and agree to the above:

Patient Signature: _____ Date: _____

Guardian or Responsible Parties Signature: _____

Guardian or Responsible Parties Social Security #: _____

WORKERS' COMPENSATION BOARD
New York State

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 / 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: _____ **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. 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: _____/_____/_____

ASSIGNMENT AND INSTRUCTION FOR
DIRECT PAYMENT TO DOCTOR

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

Carmel Medical Care, PC
PO BOX 358
Paramus, NJ 07653
(212) 831-1340

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make the check out in my name and mailed directly to:

PO BOX 358
Paramus, NJ 07653
(212) 831-1340

For the professional 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, in a current manner, any balance of said professional service charges over and above this insurance payment.

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

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

With my signature below, the full deductible or co-payment would be a financial hardship on me.

Date: _____

X _____

Policy Holder: _____

X_____

Claimant (if other than policy holder): _____

Based on the level of difficulty over the past few days, if you would or could do the following activities, circle the best answer. Please answer all questions, the staff will score your answers. Thank You.

CRC Functional Reporting Index Name: _____ Date: _____

Body Part: Neck • Upper Mid Low Back • Shoulder R L • Knee R L • Other: _____

Self Care:

Scale	0 = No Difficulty	1 = Mild Difficulty	2 = Some Difficulty	3 = Very Difficult	4 = Severe Difficulty	5 = Unable
Getting Dressed, Doing Buttons	0	1	2	3	4	5
Put on, take off shoes and socks	0	1	2	3	4	5
Groom, Wash	0	1	2	3	4	5
Driving	0 (No Limit)	1 (4 hours)	2 (2 hours)	3 (1 hour)	4 (15 min)	5 (Unable)
Cook, prep food	0	1	2	3	4	5
Total: ___/25	0					

Changing and Maintaining Body Position:

Squat	0	1	2	3	4	5
Get in/out: chair, car, bed, bath	0	1	2	3	4	5
Standing	0 (No Limit)	1 (4 hours)	2 (2 hours)	3 (1 hour)	4 (10-30 min)	5 (Unable)
Sitting	0 (No Limit)	1 (4 hours)	2 (2 hours)	3 (1 hour)	4 (10-30 min)	5 (Unable)
Sleeping OR	0 (All Night)	1 (6-7 hours)	2 (4-5 hours)	3 (2-3 hours)	4 (1-2 hour)	5 (Unable)
Sleep with Meds	--------	-------	(All Night)	(4-6 hours)	(2-3 hours)	(1-2 hours)
Total: ___/25	0					

Mobility:

Clean house, perform chores	0	1	2	3	4	5
Travel (cab, bus, train, plane)	0	1	2	3	4	5
Walk	0 (No Limit)	1 (One mile)	2 (1 block)	3 (Btw Rooms)	4 (3-5 Steps)	5 (Unable)
Walk Speed	0 (Run/Sprint)	1 (jog)	2 (Fast Walk)	3 (Normal)	4 (Slowly)	5 (Unable)
Stairs Up/Down	0 (No Limit)	1 (30 steps)	2 (20 Steps)	3 (10 steps)	4 (1-3 steps)	5 (Unable)
Total: ___/25	0					

Handling Objects:

Use tools, appliances	0	1	2	3	4	5
Open doors, jars, bottles	0	1	2	3	4	5
Lift Object from floor	0 (25+ Lbs)	1 (20 Lbs)	2 (15 Lbs)	3 (10 Lbs)	4 (1 - 5 Lbs)	5 (Unable)
Lift Object Overhead	0 (25+ Lbs)	1 (20 Lbs)	2 (15 Lbs)	3 (10 Lbs)	4 (1 - 5 Lbs)	5 (Unable)
Carry bag, box, suitcase	0 (25+ Lbs)	1 (20 Lbs)	2 (15 Lbs)	3 (10 Lbs)	4 (1 - 5 Lbs)	5 (Unable)
Total: ___/25	0					

Totals (add up above totals for total score /100, multiply each category x 4 for category score /100):

Total: ___/100	**Self Care = _____/100**	**Position = _____/100**	**Mobility = _____/100**	**Objects = _____/100**

Rating:	**CH: 0**	**CI: 1 to 19**	**CJ: 20 to 39**	**CK: 40 to 59**	**CL: 60 to 79**	**CM: 80 - 99**	**CN: 100**

 Rev 20140529

Limited Release of Health Information (HIPAA)

State of New York - Workers' Compensation Board

C-3.3

WCB Case No. *(if you know it):*_____

To Claimant: If you received treatment for a *previous* injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your previous injury/illness to your employer's workers' compensation insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) says you have a right to get a copy of this form. If you do not understand this form, talk to your legal representative. If you do not have a legal representative, the Advocate for Injured Workers at the Workers' Compensation Board can help you. Call: 800-580-6665.

To Health Care Provider: A **copy** of this HIPAA-compliant release allows you to disclose health information. If you send records to the employer's workers' compensation insurer in response to this release, also mail copies to the Claimant's legal representative. (If no legal representative is listed below, send copies to the Claimant.) Health care providers who release records must follow New York state law and HIPAA.

This release is:

- **Voluntary.** Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- **Limited.** It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- **Temporary.** It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- **Revocable.** You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's workers' compensation insurer and the Workers' Compensation Board. *Note: You may not cancel this release with respect to medical records already provided.*
- **For records only.** It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's workers' compensation insurer.

This form does NOT allow your health care provider(s) to release the following types of information:

- **HIV-related information**
- **Psychotherapy notes**
- **Alcohol/Drug treatment**
- **Mental Health treatment** (unless you check below)
- **Verbal information** (your health care providers may not discuss your health care information with anyone)

Any medical records released will become part of your workers' compensation file and are confidential under the Workers' Compensation Law.

A. YOUR INFORMATION (Claimant)

1. Name:_____ 2. Social Security Number:_____-_____-_____
3. Mailing Address: _____
4. Date of Birth: _____/_____/_____ 5. Date of the current injury/illness: _____/_____/_____
6. Current injury/illness, including all body parts injured:_____

_____

7. Your legal representative's name and address (if any):_____

_____

☐ *Check here if you allow your health care provider(s) to release **mental health care** information.*

B. YOUR HEALTH CARE PROVIDER(S)

(List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers attach their contact information to this form.)

1. Provider:_____ 2. Phone Number: (_____)_____
3. Mailing Address: _____
4. Other provider (if any):_____ 5. Phone Number: (_____)_____
6. Mailing Address:_____

C. READ AND SIGN BELOW.

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

_____

Claimant's signature (ink only -- use blue ballpoint pen, if possible.) Date

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below:

_____

Your name Relationship to Claimant Signature (ink only -- use blue ballpoint pen, if possible.) Date

Versión en español al reverso de la forma.

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STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PHI

Information to be Used or Disclosed:

RELEASE OR OBTAIN ANY AND ALL MEDICAL RECORDS RELATED TO MY MEDICAL CONDITION AND TREATMENT

Purpose of the Disclosure: **COORDINATION OF CARE AND TREATMENT**

May we leave a message on your answering machine? Yes____ No____

Persons Authorized to Use or Disclose This Information:
Carmel Medical Care, Pc; Advanced Health & Injury Care; Advanced Health & Human Performance
Additional Persons to Whom Information May Be Disclosed (include relationship):
_____

Expiration Date of Authorization:
This authorization is effective through _____/_____/_____ or NO Expiration if blank, unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to our office. You should contact the HIPAA Compliance Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

Our practice will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization. A photocopy of this authorization shall have the same force and effect as an original.

Name of patient

Signature of Patient Date

Carmel Medical Care, PC
91 Gleneida Ave; Carmel, NY 10512
P: (845) 228-7000 F: (845) 228-5485

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES*

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Carmel Medical Care, PC Notice of Privacy Practices*. By signing below, I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices*.

_____ _____

Patient Name (Type or Print) Date

_____

Signature

*A copy of our Privacy Practices is available on our website: www.advancedhealthny.com, posted in our office or upon request.