Multi-Specialty Pain Management, PC

3713 East Tremont Avenue Lower Level Bronx, NY 10465
Tel. (718) 597-4878 Fax (718) 597-4877

Demographics

Name:________________________________ **DOB:**___/___/_____
Address: ____
____
SSN: ______ - ____ - _______ **Gender:** ☐ M ☐ F **Marital Status:** ☐ S ☐ M ☐ D ☐ W
Primary Language: ☐ English ☐ Spanish ☐ Indian ☐ Russian ☐ Other ☐ Declined
Home #: ________________ **Cell #:** ________________ **Work #:** ________________
Email: ________________________

Occupation:________________________
Employer: ________________________ **Employer Address:**________________________
Referring MD: ________________________ **Primary MD:** ________________________
Emergency Contact:________________________ **Phone #:**________________
Relationship:________

Pharmacy Name: ________________________ **Pharmacy Address:** ________________________
Pharmacy Phone: ________________________ **Pharmacy Fax:** ________________________
How did you hear about our office?____

Worker's Compensation Insurance

Date of Accident: ____/____/______
Worker's Comp Carrier Name: ____
Worker's Comp Carrier Address: ____
Carrier Case#:________________________________ **WCB#:**________________

Adjuster/Case Mgr Name: ________________________
Phone #: ________________________ **Ext.**__________

Body part(s) injured established: ____

Attorney Name: ____
Address: ____
Phone #: ________________________ **Fax#:**________________________

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PROVIDER: Brian Haftel MD,

NEW WORK WORKER'S COMPENSATION INSURANCE LAW
ASSIGNMENT OF INSURANCE BENEFITS

Patient Name: ______________________ Insurance Co.: ____________________________

Date of Accident: ___________________ Insured Name: ____________________________

In consideration of service render or to be rendered to the above named patient, I hereby authorize and assign payment directly to the above name provider of any and all first party Workers' Compensation benefits to which I may otherwise be entitled for services rendered by the provider, but not to exceed the provider's charges for such services as entitled by the schedule of the Workers' Compensation Board.

____

IN CASE OF DENIAL FROM CARRIER

In consideration of care and services rendered or about to be rendered to myself during disability suffered as a result of an accident which occurred on or about ______________, I hereby assign to the provider, a portion of the proceeds of any settlement or judgment to which I may become entitled from any party responsible for such accident as shall equal the full payment of said bill for such care and services, which bill is at present.

I hereby authorize and direct any party responsible for said accident and my attorney representing me in connection with any claim that I may have by reason thereof not to pay to me or anyone in my behalf any part of the portion of the proceeds hereby assigned but to retain in trust for said provider, the whole portion to pay the same without any further notice to me.

The terms of this assignment shall be part of any adjustment of any claim I may have by reason of said accident.

It is expressly understood that this assignment does not in any way relieve the patient from his obligation therefore.

WITNESS: ____________________________________

Patient's Signature or Guardian

____

____

Date Signed

MULTI-SPECIALTY PAIN MANAGEMENT

DOCTOR'S LIEN

TO: Attorney/Insurance Carrier

____
____
____

RE: Patient records and Doctor's lien

I do hereby authorize the above doctor's office to furnish you, my attorney/insurance carrier, with a full report of his case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness, which occurred/began on

____

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing him for service rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may he necessary to protect said doctor adequately.
OUTSTANDING AMOUNT TO DATE: $________________________________

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.
I fully understand that I am responsible to notify the above doctor's office if I change attorneys or if my case is dropped. My attorney also is to notify the above doctor's office if the patient changes attorneys or if the patient's case is dropped.

DATED: ___________ **Patient's signature**: ________________________________

The undersigned, being attorney of record or authorized representative of insurance Carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above named doctor.

DATED: ___________ **Attorney Signature:**________________________________

NOTICE: Please date, sign, and return one copy to doctor's office at once.

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Brian Haftel, MD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____,
(insert patient's name) Acknowledge receipt this day from MULTI-SPECIALTY PAIN MANAGEMENT, PC of a copy of the NOTICE OF PRIVACY PRACTICES of MULTI-SPECIALTY PAIN MANAGEMENT, PC.

DATE: ____________________

____
(Patient's Signature)

Received By:

____
(Print Name Of Staff Member)

____
(Signature of Staff Member)

Multi-Specialty Pain Management, PC

3713 East Tremont Avenue Lower Level Bronx, NY 10465
Tel. (718) 597-4878 Fax (718) 597-4877

Name: ____________________
Account: __________________

Notification Policy:

It is our policy not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. When returning calls and an answering machine picks up, we do not leave a message unless it is an appointment reminder. Information also will not be left with an authorized person who may answer the phone.

If you would like to have information released to someone other than yourself, please complete the following:

I authorize the staff of Multi Specialty Pain Management to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information chanes:

____ Yes ____ No **Home Telephone:**______________________________

____ Yes ____ No **Home Answering Machine:**______________________________

____ Yes ____ No **Home Fax:** ______________________________

____ Yes ____ No **Work Telephone:**______________________________

____ Yes ____ No **Work Fax:**______________________________

____ Yes ____ No **Cell Phone and Voice Mail:**______________________________

____ Yes ____ No **Pager :**______________________________

Please list names of authorized people we may leave message with (i.e. spouse, boyfriend, girlfriend, parent, grandparent, etc).

______________________________ Yes ____ No ___
name relationship

______________________________ Yes ____ No ___
name relationship

______________________________ Yes ____ No ___
name relationship

______________________________ Yes ____ No ___
name relationship

Who may we discuss your financial situation with:

______________________________ Yes ____ No ___
name relationship

______________________________ Yes ____ No ___
name relationship

Signature: ______________________________ **Date:** __________

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): ______________

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

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: ____/____/____

WORKERS' COMPENSATION BOARD

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.

WORKERS' COMPENSATION BOARD

Divulgación limitada de información sobre la salud (HIPAA)

C-3.3

Estado de NuevaYork - Junta de Compensación Obrera (WCB)

WCB Case No. (if you know it) (Número de caso WCB *[si lo sabe]*)

Al reclamante: Si usted recibió tratamiento por una lesión anterior en la misma parte del cuerpo o por una enfermedad similar a la que motiva ahora su reclamación, complete este formulario. Este formulario les permite a los proveedores de salud que usted señala a continuación divulgar a la compañía de seguros de compensación obrera de su empleador la información sobre su salud relacionada con su lesión/enfermedad anterior. La Ley federal HIPAA (Ley de portabilidad y responsabilidad del seguro de salud de 1996) establece que usted tiene derecho a recibir una copia de este formulario. Si no comprende este formulario, hable con su representante legal. Si no tiene un representante legal, el Representante de los obreros lesionados de la Junta de Compensación Obrera puede ayudarlo. Llame al 800-580-6665.

Al proveedor de salud: Una **copia** de esta divulgación, redactada según lo que establece la ley HIPAA, le permite divulgar información sobre la salud. Si envía los registros al asegurador de compensación obrera del empleador en respuesta a la presente divulgación, también debe enviar por correo copias al representante legal del reclamante. (Si a continuación no se especifica un representante legal, envíe las copias al reclamante). Los proveedores de salud que divulgan los registros deben cumplir con las leyes del estado de Nueva York y la HIPAA.

Esta divulgación es:

- **Voluntaria.** Su(s) proveedor(es) de salud deben otorgarle la misma atención, condiciones de pago y beneficios, independientemente de que usted firme este formulario o no.
- **Limitada.** Le otorga a su(s) proveedor(es) de salud permiso para divulgar únicamente los registros médicos que se relacionen con la enfermedad/afección anterior que usted describe a continuación.
- **Temporal.** Termina cuando se otorgue o desestime su actual reclamación de compensación y se hayan agotado todas las apelaciones.
- **Revocable.** Usted puede cancelar esta divulgación en cualquier momento. Para hacerlo, envíe una carta al (a los) proveedor(es) de salud que se indican en este formulario. Además, envíe una copia de su carta a la compañía de seguros de compensación obrera de su empleador y a la Junta de Compensación Obrera. *Nota: No podrá cancelar esta divulgación en lo que se refiere a registros médicos que ya se hayan provisto.*
- **Solamente para registros.** Le otorga a su(s) proveedor(es) de salud que se indica(n) en este formulario permiso para enviar copias de sus registros de salud a la compañía de seguros de compensación obrera de su empleador.

Este formulario NO autoriza a su(s) proveedor(es) de salud a divulgar los siguientes tipos de información:

- **Información relacionada con el VIH**
- **Notas de terapia psicológica**
- **Tratamientos por abuso de alcohol o drogas**
- **Tratamiento de salud mental** (a menos que usted lo indique a continuación)
- **Información verbal** (sus doctores no pueden hablar con nadie sobre su información de salud)

Los registros médicos divulgados se incorporarán a su expediente de compensación obrera y son confidenciales conforme a la Ley de compensación obrera.

CONTESTA LAS SIGUIENTES PREGUNTAS, EN INGLÉS SI ES POSIBLE, EN LOS ESPACIOS PROVISTOS Y FIRMA AL FRENTE DE LA FORMA.

A. YOUR INFORMATION (Claimant) INFORMACIÓN PERSONAL (Reclamante)

1. Name (Nombre)
2. Social Security Number (Número de seguro social)
3. Mailing Address (Dirección postal)
4. Date of Birth (Fecha de nacimiento)
5. Date of the current injury/illness (Fecha de la lesión/enfermedad actual)
6. Current injury/illness, including all body parts injured (Descripción de la lesión/enfermedad actual, incluyendo todas las partes del cuerpo lesionadas)
7. Your legal representative's name and address (if any) (Nombre y dirección de su representante legal [si corresponde])

*Check here if you allow your health provider(s) to release **mental health care** information. (Marque aquí si autoriza a su(s) proveedor(es) de salud a divulgar información sobre **tratamientos de salud mental**.)*

B. YOUR HEALTH CARE PROVIDERS (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.

SU(S) PROVEEDOR(ES) DE SALUD (Enumere todos los proveedores de salud que le han tratado por lesiones previas a las mismas areas del cuerpo ó por enfermedades semejantes.Si son más de 2 proveedores, adjunte su información de contacto a este formulario.)

1. Provider (Proveedor de salud)
2. Phone Number (N° de teléfono)
3. Mailing Address (Dirección postal)
4. Other provider (if any) (Otro proveedor [si corresponde])
5. Phone Number (N° de teléfono)
6. Mailing Adress (Dirección postal)

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. **LEA Y FIRME A CONTINUACIÓN.** Por la presente solicito que los proveedores de salud aquí enumerados le provean al asegurador de compensación obrera de mi patrono copias de todos los records médicos relacionados a cualquier lesión/enfermedad aquí enumeradas.

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below: (**Si el reclamante no puede firmar**, la persona que firme el formulario en su nombre y representación debe llenar y firmar a continuación)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Claimant's signature (Firma del reclamante) use solo tinta - preferiblemente azul Date (Fecha)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Your name (Su nombre) Relationship to Claimant (Relación con el reclamante) Signature(Firma) Date(Fecha)

Instructions for Completing Form C-3, "Employee Claim"

Please complete this form and send it to the Workers' Compensation Board centralized mailing address listed at the bottom of these instructions. If you need additional help in completing this form, contact the Workers' Compensation Board at **1-877-632-4996. You may also fill this form out online at: http://www.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):

Item 1: Enter your full name, including first name, middle initial, and last name.
Item 2: Enter your date of birth in month/day/year format. Include the four digit year.
Item 3: Enter your mailing address, including P.O. Box, if applicable, city or town, state, and Zip code.
Item 4: Enter your Social Security Number. This is very important to help service your claim faster.
Item 5: Indicate the primary contact phone number, including area code. This may include a cell phone number.
Item 6: Indicate your gender (Male or Female).
Item 7: Board hearings are conducted in English. If you will need a translator to understand the proceeding, the Board will provide one. Check Yes and indicate the language needed.

Section B - Your Employer(s):

Item 1: Indicate the employer you were working for at the time you were injured or became ill.
Item 2: Enter the phone number for this employer, either a primary contact number or the number for your supervisor.
Item 3: Enter the employer's address, including P.O. Box, if applicable, city or town, state, and Zip code.
Item 4: Indicate the date you were hired by this employer.
Item 5: Enter your direct supervisor's name, whom you report to on a regular basis.
Item 6: If you have more than one job, please indicate the names and addresses of all other employers you work for besides the one you were injured at. Please attach a separate sheet if you need more room.
Item 7: Check Yes if you lost time from any of your other jobs as a result of your injury or illness; otherwise, check No.

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

Item 1: Indicate your current job title or job description (e.g., warehouse worker).
Item 2: Indicate your typical work activities for this job (e.g., keeping inventory, unloading trucks, etc.).
Item 3: Check the type of job you had.
Item 4: Enter your gross pay (before taxes) per pay period.
Item 5: Indicate how often you received a paycheck (weekly, bi-weekly, etc.).
Item 6: Indicate if you received any tips or lodging in addition to your regular pay. If you did, describe them.

Section D - Your Injury or Illness:

Item 1: Enter the date when you were injured or the first date you noticed you became ill. Enter the date in month/day/year format. Include the four digit year. If this is an illness or occupational disease, then skip item 2.
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 on what date you stopped working. If you have not stopped working, check No and skip to the next section.

Section E - Return to Work (cont):

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 believe 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 Workers' Compensation Board centralized mailing address. 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, contact the Workers' Compensation Board at 1-877-632-4996.
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 he/she is 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, his/her 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

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

❑ Medical Record from (insert date) ____________ to (insert date) ____________

❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

❑ Other: ____________________

____

Include: (*Indicate by Initialing*)

________ **Alcohol/Drug Treatment**

________ **Mental Health Information**

________ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here ________ I authorize ____________________

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

____________________ Date: ____________________

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR 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 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 ____________________________________

____

TO THE CLAIMANT

Workers' 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 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 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 employer 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 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 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 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 carrier of liability for medical treatment is approved.

MULTI-SPECIALTY PAIN MANAGEMENT, P.C.

BRIAN S. HAFTEL M.D., DIRECTOR

INFORMATION SHEET AND INFORMED CONSENT

At Multi-Specialty pain management P.C. we firmly believe that "every human being has the right to determine what shall be done with his own body". During the course of your treatment and evaluation here, you may be subjected to a number of different types of tests and treatments. It is our responsibility to explain the nature and purpose of these as well as known risks, benefits and alternatives. Listed below is a summary.

MRI (magnetic resonance imaging) is an imaging technique that uses electromagnetic forces, not potentially harmful radiation. It is generally safe but should not be performed in individuals who have a *pacemaker* or *metal* in their body from a previous surgery or injury. **MRI WITH CONTRAST** is performed with intravenous administration of a contrast agent. Allergic reaction or mild side effects are possible. If you have any *known allergies*, please inform your doctor of them. *Claustrophobic* individuals should discuss the possibility of sedation or other alternatives to MRI with the doctor prior to scheduling this test.

PHYSICAL THERAPY is a treatment program that is individually designed to relieve pain, rehabilitate injured tissue, and restore functional ability. Various modalities may be utilized including massage, electrical stimulation, ultrasound, traction, etc. The physical therapist will further explain the treatment plan to you. Physical therapy may result in increased soreness and discomfort initially since injured tissue is being rehabilitated. This should improve as the healing process occurs. If you are experiencing significant or ongoing pain, please bring this to the attention of your therapist and doctor.

SSEP (somatosensory evoked potential) is an electrodiagnostic test that measures the conduction of impulses from the arms and/or legs, through the spinal cord, to the brain. It requires a small electrical current but is not painful. **NCV** (nerve conduction velocity) is an electrodiagnostic test that measures the conduction of impulses in the peripheral nerves of the arms and/or legs. It requires a slightly stronger electrical impulse than the SSEP but both the NCV and SSEP are generally safe and well tolerated.

BAER (brainstem auditory evoked response) is an electrodiagnostic test that evaluates the auditory and vestibular system. It is erformed by delivering a series of "clicks" in each ear. **VER** (visual evoked response) is an electrodiagnostic test that evaluates the visual system. It is performed by delivering a series of light flashes. **EEG** (electroencephalogram) is an electrodiagnostic test that records the brain's electrical activity. The machine delivers no electrical current. This test can be performed either with paste or small needle electrodes.

EMG (electromyography) is an electrodiagnostic test which detects muscle and nerve damage. It requires placement of a thin needle in various muscles. In general, it is a safe and well-tolerated procedure although there is a small risk of bleeding, infection, and damage to adjacent structures. If you have a *bleeding disorder* or take *anticoagulants like coumadin*, please bring this to the attention of the doctor.

MEDICATIONS may be prescribed. All drugs have potential side effects and interactions. Your doctor will discuss these with you when and if medications are prescribed.

INJECTION THERAPY consists of administration of local anesthetics (such as lidocaine) and/or steroids (such as cortisone). These medications are injected into the appropriate location (such as a joint, trigger point, nerve, or epidural space) to relieve pain and inflammation and promote healing. In general, these procedures are safe and well tolerated although associated risks include but are not limited to bleeding, infection, and damage to adjacent structures. There is a risk of headaches associated with the epidural injection. Furthermore, potential side effects of local anesthetics include but are not limited to dizziness, drowsiness, allergic reaction, low blood pressure, and slow heart rate. Potential side effects of steroids include but are not limited to fluid retention, ulcers, and increased blood sugar. These side effects usually occur with long-term administration or over-dosage. Injection therapy is effective since the medication is delivered directly to the injured tissue, lower doses are required, and there are fewer, if any, side effects.

I hereby authorize Dr. Haftel and his associates to provide such medical care and to administer such treatment as deemed necessary or advisable to me each time that I am present in the office. Such medical care and treatments may include but are not limited to administration and/or injection of pharmaceutical agents and medications. To the extent possible, I have been informed of risks and complications that may occur and alternatives that may be available.

~~Print name~~ ______________________________

Sign name X ______________________________ Brian S. Haftel, MD

MULTI-SPECIALTY PAIN MANAGEMENT P.C.

3713 East Tremont Avenue, Bronx, NY 10465
Telephone: 718-597-4877 Facsimile: 718-824-8026, 718-597-4877

AGREEMENT OF RELEASE AND WAIVER OF LIABILITY

I, ____, hereby agree to and initial the following:

1. That I am participating in a one on one exercise program offered by **MULTI-SPECIALTY PAIN MANAGEMENT P.C.** (hereafter referred to as **MSPM**) during which I will receive information about health and fitness. I recognize that fitness programs require physical exertion which may be strenuous and may cause physical injury. I am fully aware of the risks and hazards with the access of the gym while performing the exercises and I am aware of the risk with ultrasound, bike equipments, electric stimulation, hot packs, cold packs, paraffin wax and any physical therapy equipments used for performing my treatment. _____ (initial)

2. I understand that it is my responsibility to consult with a physician prior to and regarding my participation in the one on one exercise program. I represent and warrant that I am physically fit and I have no medical condition which would prevent my full participation in the one on one exercise program. ____ (initial)

3. In consideration of being permitted to participate in the one on one exercise program, I agree to assume full responsibility for any risks, injuries, or damages, known or unknown, which I might incur as a result of participating in the program. If, however, I observe any unusual significant hazard during my participation, I will remove myself from participation and bring such to the attention of management. _____ (initial)

4. In further consideration of being permitted to participate in the one on one exercise program, I knowingly, voluntarily, and expressly waive any claim I may have against **MSPM** or ________________ or any therapist, for injury or damages that I may sustain as a result of participating in the program. _____ (initial)

5. I, my heirs or legal representatives forever release, waive, discharge and convent not to sue **MSPM** or ________________ or any therapist, for injury or death caused by their negligence or other acts. _____ (initial)

6. I, ______________________ understands that if I am being treated by MULTI-SPECIALTY PAIN MANAGMENT outpatient physical therapy, I will inform the therapist and the administration if I have already used or has a remaining therapy visits from my insurance. ______(initial)

7. **I also realize that I will be responsible for any payments MULTI-SPECIALTY PAIN MANAGMENT that I have not previously informed "Multi-Specialty Pain Management" of.** ____ (initial)

I have read the above release and waiver of liability and fully understand its contents. I voluntarily agree to the terms and conditions stated above. _____ (initial)

_____________________________ Date ___/____/______

PATIENT SIGNATURE

If participant is under 18:

AS LEGAL GUARDIAN OF (PRINT) ______________________________________, I CONSENT TO THE ABOVE TERMS AND CONDITIONS.

_____________________________ Date ___/_____/_____

PARENT OR GUARDIAN SIGNATURE

Multi-Specialty Pain Management P.C.
3612 East Tremont Avenue
Bronx, New York 10465

General Release

I understand that Multi-Specialty Pain Management, P.C., is a medical practice that has contracted with a third party to provide complimentary transportation for patients who, due to a lack of transportation would otherwise be unable to receive medically necessary care.

In exchange for such transportation, I, on behalf of myself, my heirs, executors, administrators and assigns, do hereby:

(1) Assume full responsibility for utilizing the transportation services provided by any such third party.

(2) Forever release, discharge, indemnify, defend and hold harmless Multi-Specialty Pain Management, P.C., its successors and assigns, employees, officers, directors and agents and each of their heirs, executors and administrators, from any and all claims, demands, liability, fees, and costs of any kind whatsoever, including attorneys' fees, in law or in equity, that I may have or claim to have on account of or in any way related to, any and all personal injury, property damage or any other claims of whatever nature and however incurred arising from the actual transportation to and from Multi-Specialty Pain Management, P.C., the proposed transportation, the cancellation or delay of the transportation, and/or the failure to provide initial or return transportation.

(3) Acknowledge my understanding that Multi-Specialty Pain Management, P.C. is not responsible for any personal property left in any transport vehicle.

I understand that upon request to Multi-Specialty Pain Management, P.C. I may be given the direct contact information for any third party providing such transportation.

This General Release may only be changed in writing.

Dated: ______________________________

____
Patient Name

____
Signature (Signature of Parent/Legal Guardian, if applicable)

____
Name of Parent/Legal Guardian, if applicable