Mt. Lookout Chiropractic
& Sports Injury Center

455 DELTA AVE., SUITE 1
CINCINNATI, OH 45226
(513) 321-8484

CONFIDENTIAL PATIENT HISTORY

Date _____

Name (including middle initial) _____

Male ☐ Female ☐ Marital Status: M S W D O

Address _____ No. of Children _____

City _____ ST _____ Zip _____ Social Security Number _____

Age _____ Birth Date _____ Email Address _____

Home Phone _____ Cell Phone _____

Occupation _____ Employer _____

Address _____

City _____ ST _____ Zip _____ Work Phone _____

Name of Spouse _____ Spouse Social Security Number _____

Spouse Employer _____ Work Phone _____

Name of Your Insurance Company _____

Name of Emergency Contact _____ Phone _____
(Nearest relative or friend, not spouse)

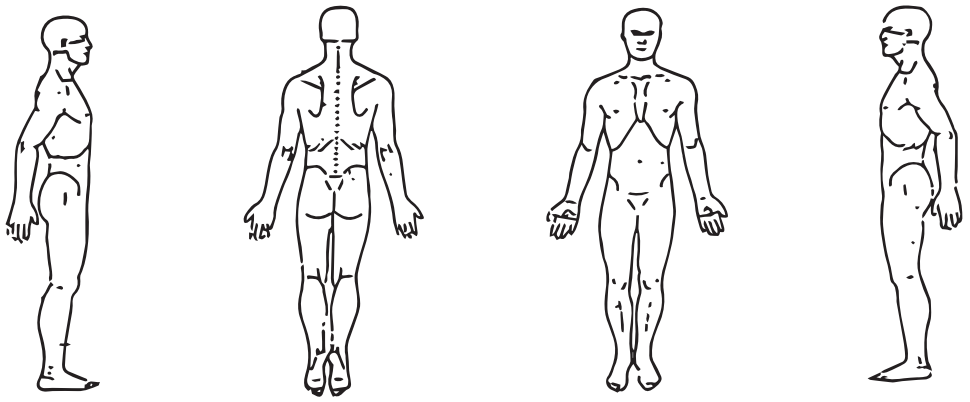
How do you prefer to be verbally addressed? _____

Whom may we thank for referring you? _____

Present Complaint _____

_____

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING, ETC.



Patient Name _____ **Date:** _____

When did your problem begin? Specific date if possible _____

How did your problem begin? _____

_____

In the past have you had anything similar to this? ☐ YES ☐ NO Please explain _____

_____

Please describe the character of your current pain. You may check one or more answers.

☐ Sharp ☐ Stabbing ☐ Burning ☐ Shooting ☐ Aches ☐ Soreness
☐ Weakness ☐ Throbbing ☐ Numbness ☐ Dull ☐ Constricting ☐ Stiff
☐ Other _____

On a Scale from 0-10, with 10 being the worst pain you have experienced and 0 being no pain.
What is your current scale of pain? 0 I 2 3 4 5 6 7 8 9 I0

How often are the complaints present?
☐ Constant/IOO% of time ☐ Frequent/75% ☐ Intermittent/50% ☐ Occasional/25%
Comments: _____

Is the pain: ☐ Increasing ☐ Decreasing ☐ Not Changing ☐ Varies

Pain is aggravated by: ☐ Walking ☐ Sitting ☐ Standing ☐ Riding in a car ☐ Lifting
☐ Bending ☐ Stretching ☐ Twisting ☐ Running ☐ Transitioning from seated to standing
☐ Other _____

Pain is reduced by:
☐ Medicine ☐ Exercise ☐ Rest ☐ Physical Therapy ☐
☐ Other _____

What would you like to do, but can't, because of your pain? _____

_____

Are your complaints, **in any way**, affecting your ability to work or be active?
☐ No effect ☐ Some physical restrictions ☐ Unable to perform regular duties

Is there any dizziness associated with symptoms? ☐ YES ☐ NO

Any fever or chills? ☐ YES ☐ NO

Any change in bowel or bladder (bathroom) function? ☐ YES ☐ NO

Are your complaints affecting your ability to sleep? ☐ YES ☐ NO Explain: _____

On average, how many hours of sleep do you get per night? _____

Do you sleep through the night uninterrupted? ☐ YES ☐ NO ☐ Sometimes

How do you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

For your present complaint have you seen any other doctors or had any physical therapy? ☐ YES ☐ NO

If yes, who? _____ What treatment? _____

Patient Name _____ **Date:** _____

FAMILY DOCTOR/PRIMARY CARE PHYSICIAN _____

We normally keep your family doctor and/or referring physician informed regarding your care at this office.

Is that okay? ☐ YES ☐ NO Please specify name and address: _____

_____

MEDICAL HISTORY

- ☐ Anemia
- ☐ Arthritis
- ☐ Cancer
- ☐ Cardiovascular Problems
- ☐ Holter Monitor-currently wearing?
- ☐ Pacemaker
- ☐ Currently Pregnant
- ☐ Low Blood Pressure ☐ controlled ☐ uncontrolled
- ☐ High Blood Pressure ☐ controlled ☐ uncontrolled
- ☐ Depression
- ☐ Dizziness/Fainting
- ☐ Fractures
- ☐ Headaches
- ☐ Hepatitis/HIV
- ☐ Kidney Problems
- ☐ Respiratory Problems
- ☐ Asthma ☐ controlled ☐ uncontrolled
- ☐ COPD ☐ controlled ☐ uncontrolled
- ☐ Seizures
- ☐ Thyroid Problems
- ☐ Diabetes ☐ controlled ☐ uncontrolled
- ☐ Other

If you checked any above, please explain: _____

_____

Have you missed any days of work or school due to the current condition? ☐ YES ☐ NO Dates missed: _____

Have you **ever** broken any bones? ☐ YES ☐ NO Explain: _____

Have you been in the hospital or had surgery for **any** reason? ☐ YES ☐ NO

Please explain: _____

_____

_____

Have you ever been in an accident? ☐ YES ☐ NO Please explain: _____

_____

What Supplements are you taking? _____

_____

_____

_____

Consume alcohol? ☐ YES ☐ NO How Much: _____

What is your exercise routine? _____

_____

Other health concerns: _____

_____

_____

Patient Name_____ **Date:** _____

EHR INFORMATION

Smoking Status: ☐ Every Day Smoker ☐ Occasional Smoker ☐ Former Smoker ☐ Never Smoked

Are you currently taking any medications? Please include all prescription and non-prescription. (e.g. Ibuprofen, Tylenol, Aleve)

Medication Name	Dosage and Frequency (i.e. 5mg per day, etc.)

Family Medical History (Record one diagnosis in your family history and the affected relative)

Diagnosis (Write in below)	Father	Mother	Sibling	Offspring

Preferred Language _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC EXAMINATION AND TREATMENT On occasion, some patients experience increased discomfort following chiropractic care and examination. Chiropractic physical examination and treatment may involve bending and physically challenging joints and soft tissues (e.g. muscles and ligaments) of the spine and extremities, and it can possibly lead to temporary feelings of soreness or pain. During treatment, the Doctor of Chiropractic may use their hands or mechanical devices to move, adjust, or manipulate joints and mobilize soft tissues. With certain soft tissue therapies, light to moderate bruising may also occur. This is nearly always a temporary issue that occurs while the area under care is undergoing therapeutic change. Patients reserve the right to consent to, or refuse, certain aspects of care once therapeutic options have been presented.

RISKS OF CHIROPRACTIC CARE AND TREATMENT I understand and have been informed that there are risks of side effects and complications anytime a healthcare provider is asked to intervene in an encounter with a patient. I have been informed of the following: that although the risk of serious complications from chiropractic treatment are rare and unlikely, events ranging from soreness, sprains and strains, to fracture or dislocation, to injuries of the spinal discs, nerves and cord have occurred. Cerebrovascular accidents, such as a stroke, have also been reported and that these have been estimated to occur in 1 in 2 million to 1 in 3.8 -5.8 million cervical manipulations, about the same probability of stroke occurring from turning your head or having your hair washed in a salon ("beauty parlor stroke"). It cannot be said with any certainty that the specific treatment caused the stroke or aggravated an underlying, pre-existing condition, or the treatment given was totally unrelated to the resulting stroke. You are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with cervical adjustment or manipulation is extremely remote.

I understand and I do not expect the Doctor of Chiropractic to be able to anticipate all the potential risks or complications. There may be problems or complications that might arise from treatment and recommendations other than those noted. These other events or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

I wish to rely on the Doctor of Chiropractic to exercise their best professional judgment during the course of the chiropractic examination and treatment, which the doctor feels is in my best interest, based upon the facts as then known at the time.

I will immediately notify a member of the office staff of any unanticipated side effects or adverse reactions associated with treatment. I also understand that if I become concerned about any post-treatment discomfort or, if I should develop any new or unrelated symptoms, I should call the practice for immediate attention. I also understand that if, for some reason, I am unable to reach or contact the practice, that I should telephone my personal primary care doctor or present myself to the nearest hospital emergency room.

ALTERNATIVE TREATMENTS AVAILABLE I understand that there are reasonable alternatives to treatment including, but not limited to: rest, home application of therapy, prescription or over-the-counter medication, exercise, non-treatment, treatment and evaluation by another provider, and surgery. Each is associated with their own benefits and risks. I have the right to request a referral to another provider for further evaluation, assessment, and management of my presenting condition(s) at any time.

CONSENT By affixing my signature below, I acknowledge that I have read and understood the above consent and have had the opportunity to ask questions about its content and meaning, if so desired, which have been answered to my satisfaction, **PRIOR TO MY SIGNING OF THIS CONSENT FORM.**

I, the undersigned, hereby request, consent to, and authorize Mt. Lookout Chiropractic & Sports Injury Center to conduct physical examinations, perform testing procedures as are required, and administer treatment as deemed necessary or advisable for my presenting complaint(s) that are within the scope of the practice of chiropractic care. I attest that the information provided in regards to my, or my dependents, current and past health history has been completed to the fullest extent and to the best of my knowledge and ability, and does not contain false or misleading information, nor omission. I also certify that no guarantee or assurance has been made to me as to the results that may be obtained from any treatment rendered.

I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek examination and treatment for myself or my dependent.

_____

Signature (Patient, Parent, or Legal Guardian)

_____

Print Name (Patient, Parent, or Legal Guardian)

PRIVACY PROTECTION AND AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: plan, coordinate, and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and accreditation. This includes release of information and notification of care to my primary health care and/or referring provider.

I hereby authorize Mt. Lookout Chiropractic & Sports Injury Center to release a complete report of services rendered including diagnosis, findings and details of treatment, and progress for the purpose of receiving payment for the services rendered to its authorized billing agents, my insurance carriers, employer's workers compensation insurance company, or other category of third party payers, the Social Security Administration under Title XVIII (18) of the Social Security Act, any Professional Review Organization, attorney, or other intermediaries responsible for payment of my charges and hereby release Mt. Lookout Chiropractic & Sports Injury Center from any consequences thereof. I understand that I may revoke this consent at any time by giving written notice.
Please list below the names of and your relationship to individuals whom you authorize Mt. Lookout Chiropractic & Sports Injury Center to release your protected health information.

Name and Relationship

_____

_____

_____

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Notice of Privacy Practices and that I have read or declined the opportunity to read and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by Mt. Lookout Chiropractic & Sports Injury Center to ensure the privacy of my protected health information. I understand that this acknowledgement will be placed in my electronic file and maintained for six years. A copy of this notice is available at any time upon request.

AUTHORIZATION TO ACQUIRE HEALTHCARE INFORMATION

I hereby authorize Mt. Lookout Chiropractic & Sports Injury Center to obtain details regarding my current and/or prior health care status from my primary care provider, referring provider, and/or other providers to facilitate appropriate care. All health records, diagnostic imaging results, diagnostic testing results, surgical information, and any data that are held regarding my medical and health management are applicable for release. This release does NOT allow information pertaining to drug and/or alcohol abuse, or mental health information to be included. I understand that I may revoke this consent at any time, except to the extent that action has already been taken, with written notice.

ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL POLICY

In consideration of all services provided, I hereby assign and transfer to Mt. Lookout Chiropractic & Sports Injury Center all of my rights, title, and interest to healthcare reimbursement in accordance with the terms and benefits under my insurance policy or other health benefits otherwise payable to me for those services rendered, including Medicare Part B. I certify that the health insurance information that I have provided is accurate and that I am responsible for keeping it updated.

I understand that I will be fully responsible for payment of any and all charges not paid by health insurance. I understand that the balance of my account is due in full within 30 days of notice, unless a payment plan arrangement has been made in advance. In the event that a bill is disputed, notification must be made within 30 days. If I do not notify Mt. Lookout Chiropractic & Sports Injury Center within that time, the bill will be presumed valid and due. All balances remaining unpaid after 30 days may be reported to a collection agency, and I will be responsible for all collection expenses including reasonable attorney's fees and court costs.

I hereby authorize Mt. Lookout Chiropractic & Sports Injury Center to submit claims, on my or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I have provided, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Mt. Lookout Chiropractic & Sports Injury Center directly for services rendered to me or my dependent.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Mt. Lookout Chiropractic & Sports Injury Center are paid in full. I also understand that I am responsible for all amounts not paid by my health insurance, including co-payments, co-insurances, and deductibles.

Mt. Lookout Chiropractic & Sports Injury Center accepts cash, personal check, Visa, Discover, and MasterCard. I understand that I will have to pay a $30.00 fee for each check that is returned to Mt. Lookout Chiropractic & Sports Injury Center for non-sufficient funds.

Prior balances considered delinquent must be paid prior to being seen for any further scheduled visits. Charges added to your account will be due in full when stated on the invoice.

ERISA AUTHORIZATION (EMPLOYEE RETIREMENT INCOME SECURITY ACT)

I hereby designate, authorize, and convey to Mt. Lookout Chiropractic & Sports Injury Center to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. (2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Mt. Lookout Chiropractic & Sports Injury Center and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

NOTICE OF OFFICE PROCEDURES AND COMMUNICATIONS

Many areas of our office are an open concept. While we do our best to discuss information regarding your treatment and/or accounts privately, at times other patients may be able to overhear. We ask that if you would like to discuss something more privately that you let us know.

Communications from our office including but not limited to, patient bills, letters, thank you cards, and claims sent to insurance companies are all sent out in envelopes with our office name on them.

It is the policy of Mt. Lookout Chiropractic & Sports Injury Center to not leave messages via voicemail, e-mail, or with another party regarding your care, testing results, specific follow up instructions, or other situations involving your personal health or care provided in this office or elsewhere. When needed, communications will be limited in scope and nature with as little identifying or specific information as possible, often requesting a return phone call to discuss pertinent information. However, with your consent, detailed information can be left via the following methods:

☐ I hereby authorize that Mt. Lookout Chiropractic & Sports Injury Center can leave detailed messages regarding my healthcare. **Please check all that apply.**

☐ **Cell** ☐ **Home** ☐ **Work** ☐ **Email**

☐ I hereby authorize that Mt. Lookout Chiropractic & Sports Injury Center can leave detailed messages regarding my healthcare via another person reached at the following phone numbers that I have provided:

☐ **Cell** ☐ **Home**

I, the undersigned, hereby certify that I have read, fully understand, and agree to be bound by these policies, assignment, and authorization pertaining to myself or my dependent. I have asked or have declined the opportunity to ask any pertinent questions regarding this information before applying my signature. A photocopy of this document shall be considered as effective as the original. I intend this certification to cover the entire course of treatment for my present condition and for any future conditions for which I seek examination and treatment for myself or my dependent.

_____

Signature (Patient or Responsible Party)

_____

Print Name (Patient or Responsible Party)

_____

Date

CONSENT TO TREAT A MINOR WITHOUT PARENT OR GUARDIAN PRESENT

I do hereby authorize and give my consent to Mt. Lookout Chiropractic & Sports Injury Center to provide evaluation and treatment as needed and necessary to my minor child in my absence following initial consultation.

☐ **Yes** ☐ **No**

My child will be accompanied by (check all that apply}:

☐ **Himself or Herself**

☐ **Other:** _____

☐ **Other:** _____

_____

Signature (Parent or Responsible Party)

Ohio | Bureau of Workers' Compensation

Authorization to Release Medical Information

Instructions

*You can obtain this form online at **www.bwc.ohio.gov***

- Please print or type.
- List the provider(s) you are authorizing to release medical records in the space indicated on this form.
- Please sign and date the form, and send it to the customer service office where your claim is located or to your self-insured employer.

Injured worker name (first, M.I., last)		Date of injury	Claim number
Address	City	State	Nine-digit ZIP code
Employer name	Employer MCO or QHP		

I, the above-named injured worker, understand I am allowing the Opportunities for Ohioans with Disabilities and the providers (persons or facilities) named here (_____

_____) that attend or examine me to release the following medical, psychological and/or psychiatric information (excluding psychotherapy notes) that are related causally or historically to physical or mental injuries relevant to my workers' compensation claim:

- Pathology slides and immunohistochemical staining results, if applicable;
- Hospital admission history and physical; emergency room reports; hospital discharge summaries; physician office notes; physical therapist, occupational therapist or athletic trainer assessments and progress notes; consultation reports; lab results; medical reports; surgical reports; diagnostic reports; procedure reports; nursing home and skilled nursing facilities documentation; home nursing progress notes; or other listed below.

_____.

I understand I am authorizing the release of this information to the following: the Ohio Bureau of Workers' Compensation (BWC), the Industrial Commission of Ohio, the above-named employer, the employer's managed care organization or qualified health plan and any authorized representatives.

I understand this information is being released to the above-referenced persons and/or entities for use in administering my workers' compensation claim.

This authorization to release medical, psychological and/or psychiatric information shall remain in effect for as long as my workers' compensation claim remains open under Ohio law. I understand I have the right to revoke this authorization at any time. However, I must submit my revocation in writing and file it with BWC or my self-insured employer. My decision to revoke this authorization will be effective, except in the case that any provider referenced above already has relied on my authorization and released information.

I understand the provider(s) referenced above may not make my completing and signing this authorization a condition of my treatment.

I understand the parties I am authorizing the release of information to are exempted from the federal privacy requirements of the Health Insurance Portability and Accountability Act of 1996 as they administer workers' compensation programs. Information disclosed pursuant to this authorization may be redisclosed by them and may no longer be protected by the federal privacy requirements. I understand such redisclosures may include but are not limited to the following:

- A copy of the medical information the employer receives may be forwarded to BWC by the employer;
- A copy of the medical information will be available to me or my physician of record upon request to BWC or to the employer.

Injured worker (or guardian or personal representative) signature	Date

If signed by the injured worker's guardian or personal representative, provide a description of the guardian or personal representative's authority to sign on behalf of the injured worker. _____

_____.

FINANCIAL POLICY FOR WORKERS' COMPENSATION

If you have been hurt while working, this will be classified as Workers' Compensation. We will bill the responsible party for your examination and treatment of the approved/allowed condition/area only. We will accept the payment for all covered services as payment in full. The patient will be responsible for non-covered services and expected to pay at the time service is rendered.

Prior authorization may be needed for certain services or diagnostic testing.

If your claim is disputed, you may be asked to cover the expenses during treatment by some other payment method. If the dispute is found in your favor, Workers' Compensation will reimburse you. You should acquire a Workers' Compensation attorney to handle your dispute.

Until your claim is approved it is required that you bring in a major medical/health insurance card for us to photocopy. This way we can file your health insurance if your claim fails to compensate.

You should bring any correspondence regarding your claim (ie: claim number, allowed conditions, notification of indepedent exams) to our insurance staff.

There are no charges for reports filed to the Bureau of Workers' Compensation. However, charges are made for reports to attorneys and/or credit disability carriers. Disability forms (C84, credit disability, etc.) are to be left for completion and require 5 working days for completion.

Our goal is to treat you and restore you to pre-accident status if possible. Please understand Workers' Compensation does not pay for treatment unrelated to your injury. They also may not pay for care of conditions that have reached maximum medical improvenment.

ADMINISTRATIVE FEE

With the increased cost of providing healthcare services, we are implementing a $2 admin fee per date of service, per provider to continue to offer our excellent & high standard of care.

Patient Initials_____ CA Initials_____

I have read the Financial Policy and agree to the conditions of the arrangements as outlined above. Furthermore, should I for any reason, become inactive by discontinuing care, I understand that my entire balance of professional services rendered to date will be due within 30 days from my last visit. I will allow this office to converse with my employer regarding this condition. I understand that all records, including x-rays, are part of the permanent records of this office. Copies are available at a nominal charge.

Date Signature of Patient/Guardian

Date Witness

A photo copy of this document will be treated as an original

Ohio | Bureau of Workers' Compensation

First Report of an Injury, Occupational Disease or Death

By signing this form, I:

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

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

Injured worker and injury/disease/death info.

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

Employer name

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

Location, if different from mailing address

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

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

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

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

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

Treatment info.

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

Diagnosis(es): Include ICD code(s)

Will the incident cause the injured worker to miss eight or more days of work? ☐ Yes ☐ No	Is the injury causally related to the industrial incident? ☐ Yes ☐ No

E code	11-digit BWC provider number	Date
Health-care provider signature		

Employer info.

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

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

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

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

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

For self-insuring employers only

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

Employer signature and title	Date	OSHA case number