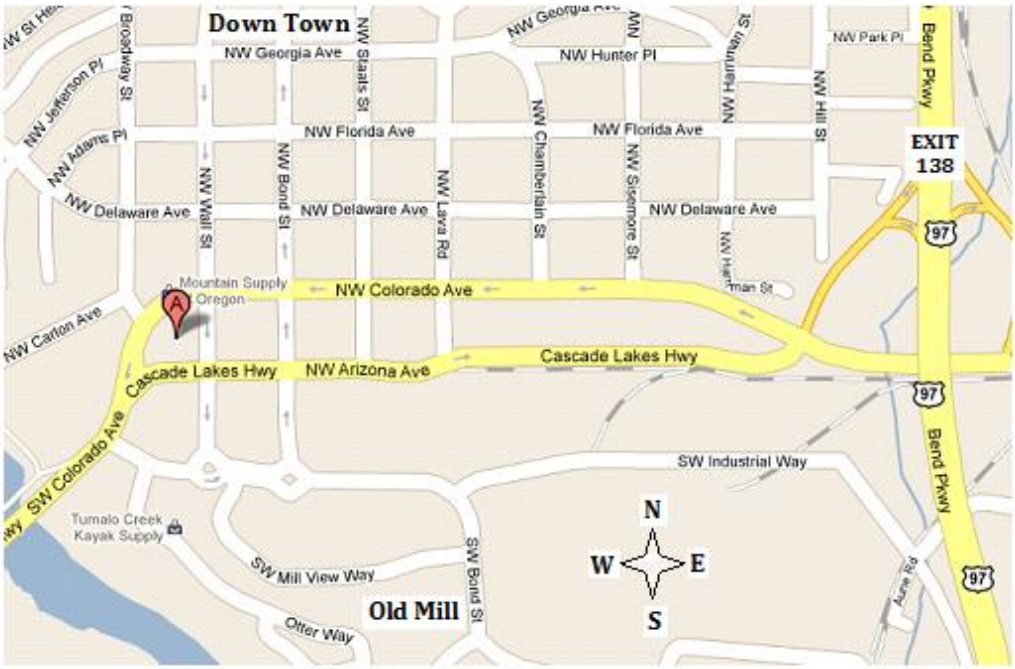
FALLING WATERS

INJURY & HEALTH MANAGEMENT CENTER

APPOINTMENT CHECKLIST

- ❒ **ARRIVAL TIME:**
  Please ensure that you come to your appointment at your scheduled arrival time. If needing to reschedule, please contact the office no less than 24 hours prior to your scheduled appointment.
- ❒ **PAPERWORK:**
  Please have this packet completed prior to arriving for your appointment. If unable to do so, our front desk staff will instruct you on an earlier arrival to ensure this can be done in the office.
- ❒ **UNDER 18 YEARS OF AGE:**
  If patient is under 18 years old, parental signatures are required on all paperwork.
- ❒ **REFERRAL / PRESCRIPTION:**
  If you are being referred to our office by another doctor or practitioner, please bring the referral or prescription with you to your appointment.
- ❒ **INSURANCE CARD AND DRIVER'S LICENSE:**
  Please ensure you bring these cards with you to your appointment as we will need copies for our records.

AREA MAP



Please print the "**DIRECTIONS TO FALLING WATERS**" page from our website for more specific directions on how to locate our clinic, or if using a GPS, enter the address below.

55 NW Wall St., Ste #100, Bend, OR 97703-3200 Phone: 541.389.4321 Fax: 541.389.4420

WORK INJURY INTAKE

First Name: _____ MI: _____ Last Name: _____ SS#: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Cell Phone: _____ May we send you text reminders? Yes/No Home Phone: _____

Email: _____ How did you hear about us? _____

DOB: ___/___/_____ Current Gender Identity: ☐ M ☐ F ☐ Other: _____ Sex Assigned at Birth: ☐ M ☐ F

Age: _____ Marital Status: ☐ Single ☐ Married/Partnered ☐ Divorced ☐ Widowed ☐ Other: _____

Children: ☐ No ☐ Yes ☐ Decline to answer, if yes, how many children: _____ What are their ages: _____

Occupation: _____ Employer: _____ Work Phone: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

May we send updates to your general medical practitioner? Yes/No Name & Clinic: _____

In compliance with the governmental EHR incentive program and CMS requirements, we ask the following:

Race (select one): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ White (Caucasian) ☐ Other ☐ I Decline to Answer

Ethnicity (select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I Decline to Answer

Preferred Language: _____

RESPONSIBLE PARTY INFORMATION

If you are the responsible party, mark "self" and move down to "Payment Information."

Person responsible for patient's charges: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

First Name: _____ MI: _____ Last Name: _____ SS#: _____

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

Sex: ☐ M ☐ F DOB: ___/___/_____ Age: _____ Cell: _____ Work Phone: _____

Employer: _____ Occupation: _____

PAYMENT INFORMATION

Please check the following payment methods that apply: ☐ Health Insurance ☐ Time of Service (Cash)

☐ This injury is related to a Work Injury ☐ This injury is related to an auto accident Date of Injury/Accident: ___/___/_____

ASSIGNMENT AND RELEASE

Scheduling an appointment reserves this time especially for you and no one else. Therefore, our office requires **24 hours notice to cancel an appointment**. **If 24 hours is not given, a charge of $20** will be billed to your account.

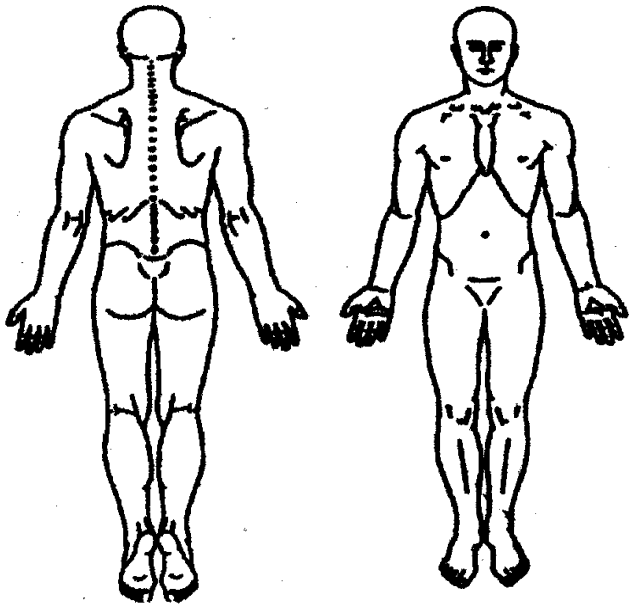
I _____ clearly **understand and agree that all services provided will be charged directly to me and that I am personally responsible for payment**. I agree to allow Falling Waters, LLC and/or provider to bill my insurance company as a courtesy and permit the release of medical records necessary to process my claims. I authorize Falling Waters, LLC to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I authorize payments to be made directly to Falling Waters, LLC and/or provider for treatment rendered. **I understand that co-payments and time of service fees are due at the time of service, I may receive an additional bill for services not covered by my insurance and any fees incurred by sending to collections will be added.**

Patient's Signature: _____ **Date:** _____
Parent or guardian signature needed if patient under 18 *mm / dd / yyyy*

CHIEF COMPLAINT FORM

Name: _____ **DOB:** _____ **Today's Date:** _____

Please list, describe, and indicate on the body diagram below, the primary reason(s) for your visit, in order of severity.



#1 Problem: _____

When did it start? _____

Was there any trauma involved? ☐ YES ☐ NO

If yes, describe: _____

_____

Are your symptoms:

☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional

Would you describe it as (check all that apply):

☐ Deep ☐ Dull ☐ Achy ☐ Sharp ☐ Shooting ☐ Burning

☐ Stiff ☐ Tight ☐ Throbbing ☐ Numb ☐ Tingly ☐ Weak

☐ Other: _____

How severe is it from 0 *(none)* to 10 *(worst imaginable)*? _____

What makes it worse? _____ Better? _____

Please list any other symptoms you feel are related to this complaint: _____

Have you had any previous evaluation or treatment for this? ☐ YES ☐ NO (if yes, please complete the following table)

Date	Provider	Diagnostic Tests	Diagnoses/Findings	Treatment	Outcome

#2 Problem: _____

When did it start? _____ Was there any trauma involved? ☐ YES ☐ NO

If yes, describe: _____

Are your symptoms: ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional

Would you describe it as (check all that apply): ☐ Deep ☐ Dull ☐ Achy ☐ Sharp ☐ Shooting ☐ Burning ☐ Stiff

☐ Tight ☐ Throbbing ☐ Numb ☐ Tingly ☐ Weak ☐ Other: _____

How severe is it from 0 *(none)* to 10 *(worst imaginable)*? _____

What makes it worse? _____ Better? _____

Please list any other symptoms you feel are related to this complaint: _____

Have you had any previous evaluation or treatment for this? ☐ YES ☐ NO (if yes, please complete the following table)

Date	Provider	Diagnostic Tests	Diagnoses/Findings	Treatment	Outcome

What are your Goals for care? (check all that apply)

- ❒ ↑ Strength / Endurance
- ❒ ↑ Flexibility
- ❒ ↓ Pain
- ❒ ↓ Stress
- ❒ ↑ Energy
- ❒ ↑ Balance
- ❒ Feel Better
- ❒ Sleep Better
- ❒ Injury Rehab: _____
- ❒ Sport Specific: _____
- ❒ ↓ Weight: _____lbs
- ❒ Achieve ideal weight: _____lbs
- ❒ Reduce medication use
- ❒ Other: _____

REVIEW OF SYSTEMS

Name: _____ **DOB:** _____ **Today's Date:** _____

CONSTITUTIONAL Rate your overall health (compared to others in your age group)

1. Excellent
2. Very Good
3. Good
4. Fair
5. Poor
6. Other _____

HEIGHT & WEIGHT *If known, what is your:*

Height: _____ Weight: _____

Please indicate any **current** or **past** symptoms of concern. Check all that apply, and **leave blank if not applicable**.

	Current	Past
1. GENERAL		
Fever/sweats		
Fatigue		
Fainting/dizziness		
Chills		
Recent/recurrent infections		
Unexplained weight loss/gain		
Difficulty losing/gaining weight		
Other:		
2. EYES / EARS / NOSE / THROAT		
Loss or change in vision		
Hearing loss or change		
Ringing/buzzing in ears		
Changes in smell		
Sinus problems		
Changes in taste		
Voice changes/loss		
Trouble swallowing		
Other:		
3. SKIN		
Dry skin		
Skin rash/lesions		
Change in nails/hair		
Other:		
4. CARDIOVASCULAR		
Chest pain		
Irregular heartbeat		
Cold fingers/toes		
Leg or ankle swelling		
Leg cramps		
Hot/cold intolerance		
Other:		
5. RESPIRATORY		
Difficulty breathing		
Chronic cough		
Chest congestion		
Sleep apnea		
Allergies		
Asthma/wheezing		
Other:		

	Current	Past
6. GASTROINTESTINAL		
Appetite/diet change		
Constipation		
Diarrhea		
Heartburn/reflux		
Stomach pain/bloating		
Nausea/vomiting		
Belching or gas		
Bowel changes		
Hemorrhoids		
Rectal bleeding		
Jaundice (yellowing)		
Ulcers		
Other:		
7. MUSCULOSKELETAL		
Multiple joint pain		
Joint swelling		
Limited mobility		
Reduced muscle mass		
Muscle weakness		
Muscle spasm		
Other:		
8. PSYCHOLOGICAL		
Personality changes		
Mood swings		
Poor concentration		
Poor memory		
Prone to stress		
Prone to depression		
Anxiety		
Anger/short temper		
Drug/alcohol abuse		
Disordered eating		
Other:		
9. NEUROLOGICAL		
Numbness/tingling		
Poor coordination		
Balance problems		
Muscle atrophy		
Changes in speech		
Other:		

	Current	Past
10. URINARY		
Pain with urination		
Urinary urgency		
Incontinence		
Nighttime urination		
Urinary tract infections		
Blood in urine		
Other:		

IF APPLICABLE

11. Do you currently, or have you in the last 3 months experienced:

	Current	Past
Menstrual cramps		
Irregular cycle		
Breast soreness		
Pain with intercourse		
Hot flashes		
Genital discharge		
Breast lumps/discharge		
Low libido		
Other:		

Are you currently pregnant? Y N

If yes, what is your due date? _____

Total number of pregnancies: _____

Total number of births: _____

Have you reached Menopause? Y N

IF APPLICABLE

12. Do you currently, or have you in the last 3 months experienced:

	Current	Past
Erectile difficulties		
Enlarged prostate		
Genital sores/lesions		
Penile discharge		
Low libido		
Other:		

OTHER CONCERNS NOT SPECIFIED?

_____ | |

_____ | |

CERTIFICATE OF AUTHENTICITY

I hereby certify that the above information is true and correct within the best of my knowledge.

Signature of Patient: _____ Date: _____

Parent or guardian signature needed if patient under 18 *mm / dd / yyyy*

HISTORY

Name: _____ **DOB:** _____ **Today's Date:** _____

HEALTH HISTORY

Do **you currently**, or **have you ever** suffered from any of the following? *(if yes please circle)* **YES** **NO**

Anemia	Colitis	Herpes	Liver disease/Cirrhosis	Sleep apnea
Aneurysm	Depression	High blood pressure	Lyme's disease	Stroke
Arthritis	Diabetes	Low blood pressure	Osteoporosis	Tendonitis
Asthma	Emphysema	High cholesterol	Pneumonia	Thyroid condition
Bleeding disorder	Gallbladder disorder	HIV/AIDS	Pancreatitis	Torn muscle/tendon
Bronchitis	Gout	Injured/pinched nerve	Recurrent sprains	Tuberculosis
Bursitis	Heart disease/attack	Irritable bowel disease	Rheumatoid arthritis	Venereal disease
Cancer	Hepatitis	Kidney stones/problems	Seizure disorder	Other: _____

SURGICAL HISTORY / HOSPITALIZATIONS ❒ None

Year	Reason	Procedure(s)

TRAUMATIC INJURY / ACCIDENTS ❒ None

Year	Trauma	Treatment

SPECIAL TESTING (X-ray, CT, MRI, etc.) ❒ None

Year	Test/Area	Results

MEDICATIONS / SUPPLEMENTS ❒ None

Med/Supp	Dosage	Reason

ALLERGIES ❒ None

Allergy	Allergic Response

Do you have a **PRIMARY CARE PROVIDER**? **YES** **NO**

If yes, who? _____

When was your **LAST PHYSICAL**? Date: _____/_____/_____

Note any concerns, if applicable:

FAMILY HISTORY

Has **anyone** in your **immediate family** suffered from any of the following? *(if yes, please circle)* **YES** **NO**

Aneurysm	Colon cancer	Gout	Irritable bowel disease	Skin condition
Arthritis	Depression	Heart disease/attack	Kidney stones/problems	Stroke
Bleeding disorder	Diabetes	High/low blood pressure	Osteoporosis	Thyroid condition
Cancer	Gallbladder disorder	High cholesterol	Seizure disorder	Other: _____

PERSONAL HISTORY

Do your **DAILY ACTIVITIES** consist of any of the following?

- ☐ Prolonged Sitting
- ☐ Prolonged Standing
- ☐ Light Labor
- ☐ Heavy Labor
- ☐ Prolonged Postures
- ☐ Awkward Positions
- ☐ Repetitive Motions
- ☐ Mental Stress

Do you feel you **SLEEP WELL** at night? **YES** **NO**

- Do you have trouble falling asleep? ☐ ☐
- Does pain impair your sleep? ☐ ☐
- If so, how many interruptions per night? _____ Time lost: _____
- Do you feel rested in the morning? ☐ ☐

Do you **EXERCISE** outside of your typical daily activities? **YES** **NO**

- What type? _____
- How many days per week? 1 2 3 4 5 6 7
- How many minutes per session? 15-30 30-60 60-90 90+
- What is the intensity level? Low Moderate High

Please note the following **HABITS**

	None	Light	Moderate	Heavy
Coffee	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐

SMOKING STATUS: □ Never Smoked □ Former Smoker □ Occasionally □ Smoke Daily If smoking, start date: _____/_____/_____

CERTIFICATE OF AUTHENTICITY

I hereby certify that the above information is true and correct within the best of my knowledge.

Signature of Patient: _____ Date: _____

Parent or guardian signature needed if patient under 18 *mm / dd / yyyy*

PROTECTED HEALTH INFORMATION DISCLOSURE

Name: _____ **DOB:** _____ **Today's Date:** _____

PLEASE REVIEW THE FOLLOWING CAREFULLY AS IT PERTAINS TO THE USAGE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

- My health information may be created or received by Falling Waters, LLC and may be in the form of written or electronic records, or spoken words. My health record may include information of my health history, health status, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

- We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff, personnel or anyone who is involved in taking care of you and your health.

- I understand that I have the right to receive and review a written description of how Falling Waters, LLC will handle my health information. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by employees, staff and other office personnel of Falling Waters, LLC and my rights regarding my health information.

- I understand the Notice of Privacy Practices may be revised periodically and my health information will not be disclosed unless I have given written consent. I understand a copy of the most recent version of Falling Waters, LLC's Notice of Privacy Practices will be posted in the reception area.

By signing this agreement I attest that I understand the information above. Our posted Privacy Health Information provides more detailed information about the usage and disclosure of your (PHI). You have the right to review and/or request a copy of this policy before you sign this consent.

Signed: _____ Date: _____

Special Permission Request:
I give my permission for Falling Waters, LLC to leave messages regarding appointments on my home/mobile telephone.

Signed: _____ Date: _____

I give my permission to have messages regarding treatment, billing and/or appointment status left with my spouse, partner, caregiver _____ _____ _____
Name of spouse/partner/caregiver Date of birth Telephone #

Signed: _____ Date: _____

This release will revoke by written permission only. I understand that I must send a written request to Falling Waters, LLC in order to revoke this release.

Signed: _____ Date: _____

TREATMENT CONSENT, FINANCIAL POLICY & DISCLOSURE

Name: _____ **DOB:** _____ **Today's Date:** _____

Please read this agreement and sign at the end indicating that you have understood and agree to the following. Please feel free to ask any questions if you would like clarification or additional information.

- Information revealed during counseling and discussion sessions is confidential. Exceptions to this confidentiality include disclosure by you regarding intention to harm yourself or others. Your record and the information contained within it will not be disclosed to others unless you direct us to do so or unless the law authorizes or compels us to do so.
- All procedures and treatment interventions (medications, nutraceuticals, therapies, spinal manipulation, injections, minor surgical procedures, etc.) carry with them both risks and benefits. Risks include, but are not limited to injury, fracture, burns, worsening of condition, adverse reactions, stroke and/or death. Not receiving or accepting treatment recommendations also carries inherent risks, including but not limited to possible worsening of condition or disease progression, which may result in reduced quality of life and/or premature death. If unsure regarding a recommended treatment or procedure, there may be additional or alternative treatments available. Therefore, you are encouraged to ask questions if you would like additional information. No guarantees can be assured regarding the outcomes of any treatment(s) or procedure(s) recommended or performed.
- **Fees are charged for professional services, and full payment with cash, check, or credit card is due at the time these services are rendered.** Treatments, consultations (whether by phone, e-mail, or in the office), detailed correspondence on your behalf are examples of professional services.
- **You are responsible for payment for office fees, treatments, and lab tests regardless of insurance coverage.** As a courtesy, we provide insurance billing service; however, this is not a guarantee of payment and each insurance plan offers different levels of reimbursement and/or coverage for services. Many "preventive approaches" to healthcare are not covered by insurance plans. **Any expense not covered by your insurance plan is your responsibility to pay in full.** At your request, you will receive a detailed receipt to request reimbursement from your insurance carrier.
- If you have a serious health problem that requires immediate attention, you should call 911, or have someone take you to the nearest hospital emergency room. If you notice an adverse effect from one of the components of your health plan, you should discontinue it then call our office and inform the provider of your concerns.
- Treatments with other physicians or healthcare providers are not necessarily to be discontinued. Please let the doctor / provider know if you are being treated by other healthcare providers (Physicians, Counselors, Therapists, etc.). Consult your prescribing Doctor before discontinuing medications. **It is your responsibility to disclose new injuries, symptoms, conditions, treatments, medications, supplements, surgeries or diagnostic procedures performed, as well as any changes in your symptoms, conditions, medications, supplements, contact information, or treatments by other providers between visits**.
- You are welcome to bring a friend or relative to your visits if such companionship is comfortable to you. Due to allergies and patient sensitivities, only registered service animals as defined by Title II and III of the ADA are allowed to accompany you into the clinic. Please have your animal clearly marked by a vest or other ID.
- You are encouraged to ask questions on any health-related topic and to take an active role in your health care. Ours is a team approach, and treatment recommendations may involve encouraging you to make changes to your diet and lifestyle that can help you improve your level of health.
- Falling Waters, LLC is owned by Shawndi Stahl, PT, MPT, David McClintock, DC, and Amanda Guy whom have financial interest in its ancillary services. If you would prefer to have any ancillary services performed elsewhere we will assist you to make arrangements.

CERTIFICATE OF CONSENT

My signature below signifies my consent to treatment and assures that the contact information, health history, and other information that I have provided on my intake forms is complete and accurate. I have read, understand and agree to the information in this packet and my questions, if any, were answered to my satisfaction.

Signature of Patient: _____ Date: _____

Parent or guardian signature needed if patient under 18 *mm / dd / yyyy*

DEPARTMENT OF CONSUMER & BUSINESS SERVICES *Workers' Compensation Division*

Worker's and Health Care Provider's Report for Workers' Compensation Claims

Health care provider instructions

The worker **should** complete the worker section of this form for the following:

- First report of injury or disease
- Request for acceptance of a new or omitted medical condition
  ("Omitted" refers to a condition the worker thinks should have been included among the conditions accepted by the insurer.)
- Report of aggravation of original injury
  ("Aggravation" means the actual worsening of a compensable condition resulting from the original injury.)
- Notice of change of attending physician or nurse practitioner.* This means the new provider will be primarily responsible for treatment.
  Being primarily responsible does NOT include:
  - *Treatment on an emergency basis*
  - *Treatment on an "on-call" basis*
  - *Consulting*
  - *Specialist care (unless the specialist assumes complete control of care)*
  - *Exams done at the request of the insurer or the Workers' Compensation Division*

*Oregon nurse practitioners, chiropractic physicians, naturopathic physicians, and physician assistants must certify with the Workers' Compensation Division to treat workers' compensation patients and get paid.

After the worker has completed and signed Form 827, give the worker copies of Form 827 and Form 3283 (included with this packet) immediately.

The worker **should NOT** complete the worker section of this form if you choose to use it for the following:

- Progress report
- Closing report
- Palliative care request
  (Palliative care makes the worker feel better but does not cure a condition. The worker must be in the workforce or in a vocational program to be eligible for palliative care.)
  The following are not palliative care:
  - *Prescriptions, prosthetics, braces, and doctors' appointments to monitor them*
  - *Diagnostic services*
  - *Life-preserving treatments*
  - *Curative care to stabilize an acute waxing and waning of symptoms*
  - *Services to a permanently and totally disabled worker*

  When requesting palliative care approval from the insurer, include the following in your request:
  - *Who will provide the care*
  - *Modalities ordered, including frequency and duration*
  - *How the need for care is related to the accepted conditions*
  - *How the care will enable the worker to continue current work or vocational training*

For these reports, you have the option of filing Form 827, submitting chart notes, or submitting a report that includes data gathered on Form 827.

Questions about name/address of insurer: *503-947-7814 or WorkCompCoverage.wcd.oregon.gov*
Questions about medical issues: *Contact the medical resolution team at 503-947-7606*
For health care providers: *www.oregonwcdoc.info*

827

DEPARTMENT OF CONSUMER & BUSINESS SERVICES — *Workers' Compensation Division*

Worker's and Health Care Provider's Report for Workers' Compensation Claims

OPTIONAL — WCD employer no.: | Policy no.:

Note to Provider: **Ask the worker to complete this form ONLY for the four filing reasons in the worker's section; do not have the worker complete or sign form if this is a progress report, closing report, or palliative care request.**

Dept. Use: Ins. no. | Occ. | Nature | Part | Event | Source | Assoc. object

Worker or provider

Worker's legal name, street address, and mailing address:

Phone:

Language preference: | Male/female ☐ ☐ | Social Security no. (see Form 3283):

Claim no. (if known): | Date/time of original injury:

Date of birth: | Occupation: | Last date worked:

Employer at time of original injury — name and street address:

Phone:

Health insurance company name and phone:

Workers' compensation insurer's name, address:

Worker

Worker: Check reason for filing this form, answer questions (if any), and sign below.

☐ **First report of injury or disease** (Do not complete or sign if you do not intend to make a claim.)
Have you injured the same body part before? ☐ Yes ☐ No If yes, when: _____

☐ **Request for acceptance of a new or omitted medical condition on an existing claim**
Condition: _____

☐ **Notice of change of attending physician or nurse practitioner**
Reason for change: _____

☐ **Report of aggravation of original injury (actual worsening of a compensable condition)**

Check here if you have more than one job. ☐

Describe accident:

By signing this form, I authorize health care providers and other custodians of claim records to release relevant medical records. I certify that the above information is true to the best of my knowledge and belief. (See back of form.)

X _____ Worker's signature _____ Date

Provider

Provider: If worker initiated this report, give worker a copy immediately.

If the worker filed this report for:

- **First report** of injury or illness – **Send this form to the workers' compensation insurer within 72 hours of visit.**
- **New or omitted** medical condition – Attach chart notes, including diagnostic codes. **Send this form to the insurer within five days of visit.**
- **Change of attending physician** or nurse practitioner – By signing this form, you acknowledge that you accept responsibility for the care and treatment of the above-named worker. **Send this form to the insurer within five days** after the change or the date of first treatment. Check the following, if applicable: ☐ **I request insurer to send its records.**
- **Aggravation of original injury** – Sign this form and **send it to insurer within five days of visit.**

If filing for progress report, closing report, or palliative care request, check the appropriate box below.

☐ **Progress report** ***OR*** ☐ **Closing report** (See instructions in Bulletin 239.)

☐ **Palliative care request –** Complete remainder of form, except Section b. **Attach a palliative care plan**; state how care relates to the compensable condition, how care will enable worker to continue work or training, adverse effect on worker if care not provided.

To get the name and address of the insurer, call the Workers' Compensation Division's Employer Index 503-947-7814, or visit online:
WorkCompCoverage.wcd.oregon.gov
To order supplies of this form, call 503-947-7627.

a

Date/time of first treatment: | Last date treated: | Was worker hospitalized as an inpatient? ☐ Yes ☐ No If yes, name hospital:

Next appointment date: | Est. length of further treatment: | Current diagnosis per ICD-9-CM codes:

b

Has the injury or illness caused permanent impairment? ☐ Yes ☐ No ☐ Impairment expected ☐ Unknown

Medically stationary? ☐ Yes (date): ☐ No (anticipated date): (Attach findings of impairment, if any.)

Work ability status:
☐ Regular work (job at injury) authorized start (date): through (date, if known):
☐ Modified work authorized from (date): through (date, if known):
☐ No work authorized from (date):

c

Chart notes: Attach chart notes to this form. The notes should specifically describe: symptoms; objective findings; type of treatment; lab/x-ray results (if any); impairment findings (if any, and note whether temporary or permanent); physical limitations (if any); palliative care plan (specify rendering provider, modalities, frequency, and duration); if referred to another physician, give the name and address; surgery; and history (if closing report).

Provider's name, degree, address, and phone: *(print, type, or use stamp)*

X _____ ***Provider's signature*** **Mark Davies, DC** ***Date***

— Original and one copy to insurer
— Retain copy for your records
— Copies (include Form 3283) to worker immediately if initial claim, new or omitted medical condition claim, aggravation claim, or change of attending physician or nurse practitioner

827

Notice to worker

Claim acceptance or denial
In most instances, you will receive written notice from your employer's insurer of the acceptance or denial of your claim within 60 days. If your employer is self-insured, your employer or the company your employer has hired to process its workers' compensation claims will send the notice to you. If the insurer or self-insured employer denies your claim, it will explain the reason for the denial and your rights.

Medical care
The health care provider must tell you if there are any limits to the medical services he or she may provide to you under the Oregon workers' compensation system.

If your claim is accepted, the insurer or self-insured employer will pay medical bills due to medical conditions the insurer accepts in writing, including reimbursement for prescription medications, transportation, meals, lodging, and other expenses up to a maximum established rate. You must make a written request for reimbursement and attach copies of receipts. Medical bills are not paid before claim acceptance. Bills are not paid if your claim is denied, with some exceptions. Contact the insurer if you have questions about who will pay your medical bills.

Payments for time lost from work
In order for you to receive payments for time lost from work, your health care provider must notify the insurer or self-insured employer of your inability to work. After the original injury, you will not be paid for the first three calendar days you are unable to work unless you are totally disabled for at least 14 consecutive calendar days or you are admitted to a hospital as an inpatient within 14 days of the first onset of total disability.

You will receive a compensation check every two weeks during your recovery period as long as your health care provider verifies your inability to work. These checks will continue until you return to work or it is determined further treatment is not expected to improve your condition. Your time-loss benefits will be two-thirds of your gross weekly wage at the time of injury up to a maximum set by Oregon law.

Authorization to release medical records
By signing this form, you authorize health care providers and other custodians of claim records to release relevant records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization.

Caution against making false statements
Any person who knowingly makes any false statement or representation for the purpose of obtaining any benefit or payment commits a Class A misdemeanor under ORS 656.990(1).

Palliative care
Palliative care is care that makes you feel better, but does not cure you of an unwanted condition. You must be in the workforce, or in a vocational program, to be allowed to have palliative care.

The following are **not** palliative care:

- Prescriptions, prosthetics, braces, and doctors' appointments to monitor them
- Diagnostic services
- Life-preserving treatments
- Curative care to stabilize an acute waxing and waning of symptoms
- Services to a permanently and totally disabled worker

If you have questions about your claim that are not resolved by your employer or insurer, you may contact:

(Si Ud. tiene alguna pregunta acerca de su reclamación que no haya sido resuelta por su empleador o compañía aseguradora, puede ponerse en contacto con):

Workers Compensation Division
(División de Compensación para Trabajadores)
P.O. Box 14480, Salem, OR 97309-0405
Salem: 503-947-7585
Toll-free: 800-452-0288

Ombudsman for Injured Workers
(Ombudsman para Trabajadores Lastimados)
350 Winter Street NE, Salem, OR 97301-3878
Salem: 503-378-3351
Toll-free: 800-927-1271

OREGON DEPARTMENT OF CONSUMER & BUSINESS SERVICES
Workers' Compensation Division

A Guide for Workers Recently Hurt on the Job

How do I file a claim?

- Notify your employer and a health care provider **of your choice** about your job-related injury or illness as soon as possible. Your employer cannot choose your health care provider for you.
- Ask your employer the name of its workers' compensation insurer.
- Complete **Form 801, "Report of Job Injury or Illness,"** available from your employer and **Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claims,"** available from your health care provider.

How do I get medical treatment?

- You may receive medical treatment from the health care provider **of your choice**, including:
  - Authorized nurse practitioners
  - Chiropractic physicians
  - Medical doctors
  - Naturopathic physicians
  - Oral surgeons
  - Osteopathic doctors
  - Physician assistants
  - Podiatric physicians
  - Other health care providers
- The insurance company may enroll you in a managed care organization at any time. If it does, you will receive more information about your medical treatment options.

Are there limitations to my medical treatment?

- **Health care providers may be *limited* in how long they may treat you and whether they may authorize payments for time off work.** Check with your health care provider about any limitations that may apply.
- **If your claim is denied, you may have to pay for your medical treatment.**

If I can't work, will I receive payments for lost wages?

- You may be unable to work due to your job-related injury or illness. In order for you to receive payments for time off work, your health care provider must send written authorization to the insurer.
- Generally, you will not be paid for the first three calendar days for time off work.
- You may be paid for lost wages for the first three calendar days if you are off work for 14 consecutive days or hospitalized overnight.
- If your claim is denied within the first 14 days, you will not be paid for any lost wages.
- Keep your employer informed about what is going on and cooperate with efforts to return you to a modified- or light-duty job.

What if I have questions about my claim?

- The insurance company or your employer should be able to answer your questions.
- If you have questions, concerns, or complaints, you may also call any of the numbers below:

Ombudsman for Injured Workers:
An advocate for injured workers
Toll-free: 800-927-1271
Email: oiw.questions@state.or.us

Workers' Compensation Resolution Section
Toll-free: 800-452-0288
Email: workcomp.questions@state.or.us

Do I have to provide my Social Security number on Forms 801 and 827? What will it be used for? You do not need to have an SSN to get workers' compensation benefits. If you have an SSN, and don't provide it, the Workers' Compensation Division (WCD) of the Department of Consumer and Business Services will get it from your employer, the workers' compensation insurer, or other sources. WCD may use your SSN for: quality assessment, correct identification and processing of claims, compliance, research, injured worker program administration, matching data with other state agencies to measure WCD program effectiveness, injury prevention activities, and to provide to federal agencies in the Medicare program for their use as required by federal law. The following laws authorize WCD to get your SSN: the Privacy Act of 1974, 5 USC § 552a, Section (7)(a)(2)(B); Oregon Revised Statutes chapter 656; and Oregon Administrative Rules chapter 436 (Workers' Compensation Board Administrative Order No. 4-1967).

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