



OM PHYSICAL THERAPY

**OM PHYSICAL THERAPY - NEW PATIENT INTAKE FORM
(Workers' Compensation)**

Welcome to OM Physical Therapy! We are here to support your journey to recovery and improve health. Please fill out this form to help us tailor our care to your specific needs.

PATIENT INFORMATION			
Patient's full name (last, first, middle)			
Home Address		City	State Zip
Birth sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN		Dob (mm/dd/yyyy)
Home phone <input type="checkbox"/> Ok to call <input type="checkbox"/> Ok to text	Cell phone <input type="checkbox"/> Ok to call <input type="checkbox"/> Ok to text	Work phone <input type="checkbox"/> Ok to call <input type="checkbox"/> Ok to text	
Email		How did you hear about us?	
Primary Care physician	Address		Phone
Referring physician (if different from primary care)	Address		Phone
Emergency contact name		Relation	Phone
Employment Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Not Working			
INJURY/ILLNESS INFORMATION			
Note: Please present a copy of your physical therapy prescription from your physician, if you have it, to the front desk during your initial visit.			
Diagnosis of your injury (if known):	Date of injury/illness (mm/dd/yyyy)	Date of surgery (mm/dd/yyyy)	
Current Injury/condition as a result of <input type="checkbox"/> Personal Injury <input type="checkbox"/> Motor Vehicle Accident/No-Fault <input type="checkbox"/> On the Job/Workers' Compensation			



WORKERS' COMPENSATION INSURANCE INFORMATION

Please carefully review the following:

Have you filled out the New York Workers' Compensation Employee Claim C-3 form to apply for workers' compensation benefits because of a work injury or work-related illness?

- **YES- Provide your workers' compensation insurance information (Only if the case has been established by New York Workers' Compensation Board)** Please present a copy of all workers' compensation-related paperwork if you are in possession of any (paperwork from New York Workers' Compensation Board, Workers' Compensation Carrier, Employer, Workers' Compensation Attorney) to the front desk during your initial visit.
- **NO- We will ask you in the end of this form to fill out New York Workers' Compensation Employee Claim C-3 form to apply for workers' compensation benefits because of a work injury or work-related illness.**

WCB Case Number (if known. It starts with the letter G):

Workers' Compensation Carrier Name (Insurance that will cover your work related injury. Your employer should provide you with the information)

Workers' Compensation Carrier Address

Workers' Compensation Carrier Case Number/WC Claim# (if you know it):

Your Workers' Compensation Attorney Name

Your Workers' Compensation Attorney Address

Phone#

Fax#

Email:

Certification

By signing below, I affirm that the information provided here is accurate to the best of my knowledge.

Signature: _____

Print Name: _____

Date: _____

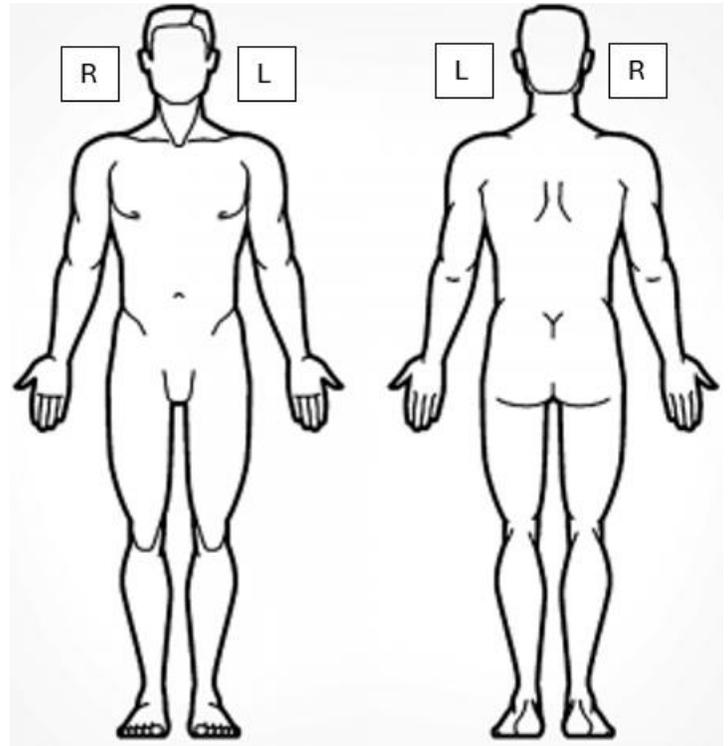
OM PHYSICAL THERAPY - COMPREHENSIVE MEDICAL HISTORY FORM

Current Condition/Major Complaints:

• **What are you/the patient being seen for?**

(Please circle where you feel pain/discomfort)

- Neck
- Shoulder
- Elbow or Upper Arm
- Forearm or Hand
- Wrist
- Mid Back
- Lower Back
- Hip
- Thigh
- Knee Lower Leg Ankle or Foot



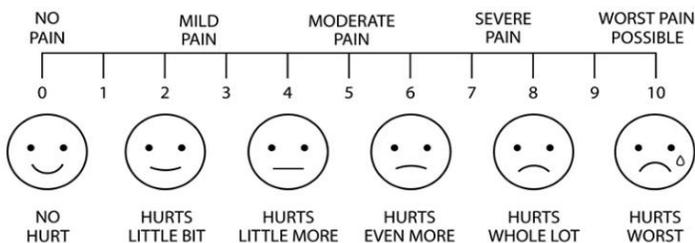
• **Date of condition onset/ When did your pain start:** _____

• **Is your current condition/complaint a result of,**

- Personal Injury Motor Vehicle Accident/No-Fault On the Job/Workers' Compensation

• **Describe pain (please circle):** Sharp Dull Aching Throbbing Cramping Burning Shooting Stabbing Constant Intermittent

• **Pain Assessment: Rate your pain on a scale of 0 to 10 (0 = No pain, and 10 = Unbearable pain)**



Pain at its best: _____

Pain today: _____

Pain at its worst: _____

What makes it worse? _____

What makes it better? _____

Does time of day affect pain? Yes No

Does pain wake you from sleep? Yes No

Daily activities affected by pain _____ %



- Do you have tingling, numbness, or loss of sensation? Yes No If so, where? _____
- Do you have weaknesses? Yes No If so, where and for how long? _____
- Do you have swelling? Yes No If so, where? _____

Lifestyle Information

- Do you use tobacco? Yes No If yes, ___ # of packs per day
- Do you consume alcohol? Yes No If yes, ___ # of drinks per day
- Do you wear glasses or contacts? Yes No
- Do you wear dentures or use a hearing aid? Yes No
- Do you have a pacemaker? Yes No
- Do you have any metal implants? Yes No
- Do you use a cane or crutches? Yes No
- Do you use a walker or wheelchair? Yes No
- Have you fallen two or more times? Yes No
- Have you sustained an injury as a result of these falls? Yes No
- For female patients only: Are you pregnant? Yes No If yes, ___ # of weeks pregnant

Current Medications: Please list all medications including prescriptions, OTCs, herbals, and any supplements.

Medication: _____ Dose: _____ Frequency: _____ Administration Route: _____

Medication: _____ Dose: _____ Frequency: _____ Administration Route: _____

Medication: _____ Dose: _____ Frequency: _____ Administration Route: _____

Medication: _____ Dose: _____ Frequency: _____ Administration Route: _____

No current medication

Surgical History List any surgeries you have had including the type and date.

Surgery Type: _____ **Date:** _____

Surgery Type: _____ **Date:** _____

Surgery Type: _____ **Date:** _____

Diagnostic and Treatment History Have you received any of the following for this condition?

- | | | |
|---|---|--|
| <input type="checkbox"/> Chiropractic Care | <input type="checkbox"/> Myelogram | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> CT Scan | <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Podiatry Services |
| <input type="checkbox"/> General Practitioner | <input type="checkbox"/> Neurological Consult | <input type="checkbox"/> Emergency Room Services |
| <input type="checkbox"/> MRI | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> X-rays |
| <input type="checkbox"/> EMG/NCV Tests | <input type="checkbox"/> Orthopedic Care | |



Past Medical History Check any conditions you currently have or have had in the past.

High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Parkinson's Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
High Cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N	COPD/Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N
Bowel/Bladder Dysfunction	<input type="checkbox"/> Y <input type="checkbox"/> N	Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N
Acid Reflux/Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N	Lupus	<input type="checkbox"/> Y <input type="checkbox"/> N
Thyroid Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Bleeding Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N
HIV/AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N	Osteoarthritis	<input type="checkbox"/> Y <input type="checkbox"/> N
Seizures/Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatoid Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N
Lyme Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Osteoporosis/Osteopenia	<input type="checkbox"/> Y <input type="checkbox"/> N
Congestive Heart Failure	<input type="checkbox"/> Y <input type="checkbox"/> N	Scoliosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Headaches/Migraines	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N	Dizziness/Fainting	<input type="checkbox"/> Y <input type="checkbox"/> N
Cardiac Bypass	<input type="checkbox"/> Y <input type="checkbox"/> N	Dementia/Alzheimer's	<input type="checkbox"/> Y <input type="checkbox"/> N
Cardiac Stent	<input type="checkbox"/> Y <input type="checkbox"/> N	Recent Infection	<input type="checkbox"/> Y <input type="checkbox"/> N
Chest Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Multiple Sclerosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N	Fibromyalgia	<input type="checkbox"/> Y <input type="checkbox"/> N
Mental Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N
If yes, what type: _____		If yes, what type: _____	
Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N	Please list allergies: _____	
Other not listed: _____			

Certification: By signing below, I affirm that the information provided here is accurate to the best of my knowledge.

Signature: _____

Print Name: _____

Date: _____



OM PHYSICAL THERAPY- NOTICE OF PRIVACY PRACTICES AND CONSENT (HIPAA)

Understanding Your Rights: Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, you have specific rights concerning the privacy of your protected health information. This information will be used in the following ways:

- **For Treatment:** To coordinate, manage, and administer your medical treatment and services among healthcare providers involved in your care.
- **For Payment:** To secure payment for health care services provided, from insurers and other third-party payers.
- **For Healthcare Operations:** To support essential healthcare operations such as quality reviews and physician evaluations.

Comprehensive Privacy Notice: I acknowledge that I have read and understood the detailed notice of privacy practices, which provides more extensive information on how my health information may be used and disclosed. I am aware that the organization may modify its privacy practices and that I can obtain the most recent version of this notice upon request.

Restriction Requests: I understand that I have the right to request restrictions on how my health information is used or disclosed for treatment purposes, although the organization is not obligated to comply with such requests.

Consent Revocation: I reserve the right to withdraw my consent at any time in writing, except to the extent that actions have already been taken based on this consent.

Instructions for the Use
of the HIPAA-compliant Authorization Form to
Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act (“HIPAA”) and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as “at the conclusion of my court case” or provide a specific date amount of time, such as “3 years from this date”.

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.



**OM PHYSICAL THERAPY- ADDITIONAL FORMS
(FOR WORKERS' COMPENSATION PATIENTS ONLY)**

If your injury is work-related (pertaining to an on-the-job incident or covered under workers' compensation), please complete the attached form. If this form has not already been submitted to the New York Workers' Compensation Board, ensure it is filled out and filed accordingly.

- **EMPLOYEE CLAIM C-3 FORM** (Fill out attached form to apply for workers' compensation benefits because of a work injury or work-related illness).



Employee Claim

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/Apartment No. City State Zip Code
4. Social Security Number: _____ - _____ - _____ 5. Phone Number: (____) _____ 6. Gender: M F X
7. Will you need a translator if you have to attend a Board hearing? Yes No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (____) _____
3. Your work address: _____
Number and Street City State Zip Code
4. Date you were hired: ____/____/____ 5. Your supervisor's name: _____
6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? Yes No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____
2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) Full Time Part Time Seasonal Volunteer Other: _____
4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____
6. Did you receive lodging or tips in addition to your pay? Yes No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ____/____/____ 2. Time of injury: _____ AM PM
3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

4. Was this your usual work location? Yes No If no, why were you at this location? _____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

YOUR NAME: _____
First MI Last

DATE OF INJURY/ILLNESS: ____/____/____

D. YOUR INJURY OR ILLNESS *continued*

- 8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? Yes No If yes, what? _____
- 9. Was the injury the result of the use or operation of a licensed motor vehicle? Yes No
If yes, your vehicle employer's vehicle other vehicle License plate number (if known): _____
If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____
- 10. Have you given your employer (or supervisor) notice of injury/illness? Yes No
If yes, notice was given to: _____ orally in writing Date notice given: ____/____/____
- 11. Did anyone see your injury happen? Yes No Unknown If yes, list names: _____

E. RETURN TO WORK

- 1. Did you stop work because of your injury/illness? Yes, on what date? ____/____/____ No, skip to Section F.
- 2. Have you returned to work? Yes No If yes, on what date? ____/____/____ regular duty limited duty
- 3. If you have returned to work, who are you working for now? Same employer New employer Self employed
- 4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

- 1. What was the date of your first treatment? ____/____/____ None received (skip to question F-5)
- 2. Were you treated on site? Yes No
- 3. Where did you receive your first off site medical treatment for your injury/illness? none received Emergency Room
 Doctor's office Clinic/Hospital/Urgent Care Hospital Stay over 24 hours
Name and address where you were first treated: _____
_____ Phone Number: (____) _____
- 4. Are you still being treated for this injury/illness? Yes No
Give the name and address of the doctor(s) treating you for this injury/illness: _____
_____ Phone Number: (____) _____
- 5. Have you had 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 they are 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: ____/____/____

Instructions for Completing Employee Claim (Form C-3)

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

In Section A, enter your name, address and other requested information.

Note on Item 7: Board hearings are conducted in English. If you need a translator, select **Yes** and indicate the language needed.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a).

The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

Section B - Your Employer(s):

In Section B, enter the name, address, phone number and other information of the employer you were working for at the time of the injury/illness.

Note: Your employer is the company or agency that issues your paycheck. If you are a contractor at a work site or office, the staffing agency or vendor who hired you is your employer, not the work site or office where you report to work.

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

In Section C, enter your job title, work activities and pay information.

Section D - Your Injury or Illness:

In Section D, enter your injury or illness information.

Item 1: Enter the date you were injured or the first date you noticed you became ill.

If this is an illness or occupational disease, skip item 2. The date you were injured must be in month/day/year format. The year should be written as four digits, e.g., 2015.

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. **If you filed a Department of Motor Vehicles Form MV-104 (Report of Motor Vehicle Accident), please submit a copy along with the C-3. This will expedite the process for you to receive potential benefits.**

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 the date you stopped working. If you have not stopped working, check No and skip to the next section.

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 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 nearest Workers' Compensation Board Office. (See below.) 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, telephone or visit the nearest Workers' Compensation Board Office listed below.
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 they are 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, their 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