Welcome to West Chester Acupuncture and Chiropractic

Dr. Julie Hilbert, DC, FIAMA, Dipl.Ac. – Dr. Burton Young, DC, FIAMA, Dipl.Ac.
6940 Tylersville Rd, West Chester, OH 45069 • 513-777-9428

WORKER'S COMPENSATION HISTORY

Name _____ Age _____ Date of Birth _____ ☐ Male ☐ Female

Address _____ City _____ State _____ Zip _____

SS# _____ Drivers Lic # _____

Employers Name _____ Tel # _____

Address _____ City _____ State _____ Zip _____

Carriers Name _____ Tel # _____

Address _____ City _____ State _____ Zip _____

Have your retained legal counsel for this injury? ☐ Yes ☐ No If yes, give name and address _____

_____

INJURY DESCRIPTION

Date present injury was received _____ Time of in jury ____ ☐AM ☐ PM Overtime: ☐ Yes ☐ No

Who saw the accident: Name _____ Title _____

Who reported the accident? Name _____ Title _____

What medical attention was rendered? _____

By whom? ☐ Nurse ☐M.D. ☐ D.O. ☐D.C ☐Other employee ☐ Other _____

How did the injury occur? _____

Chief complaint _____

Symptoms _____

Since the injury, are your symptoms: ☐ Impoving ☐ The same ☐ Getting worse

If working on a machine, give description _____

Do you use foot or hand levers? ☐ Yes ☐ No Do you work overhead? ☐ Yes ☐ No

Do you have to reach? ☐ Yes ☐ No Where? _____

Movements on the job: Do you move to your ☐ Right ☐ Left ☐ Up ☐ Down ☐ Under ☐ Over

Do you pick up or lift? ☐ Yes ☐ No If yes, how much? _____ How often? _____

From where to where? _____ Do you lift from ☐ Ground ☐ Bench ☐ Platform

☐ Box ☐ Pallet ☐ Other (Please Describe) _____

Do you lift in or out of a machine? ☐ Yes ☐ No If working at a machine, do you ☐ Sit ☐ Stand ☐ Kneel

Is your work area cluttered? ☐ Yes ☐ No If yes, with what? _____

Is your work area ☐ Oily ☐ Dirty ☐ Slippery ☐ Other _____

In your job do you push or pull? ☐ Yes ☐ No If yes, give specifics _____

Do you use a cart? ☐ Yes ☐ No ☐ Two-wheel ☐ Four-wheel Type of wheels:☐Rubber ☐Steel ☐Plastic

Condition of cart ☐ Good ☐ Bad ☐ Other _____ Number of carts being pushed or pulled at once __

Total amount of weight being pushed or pulled on a daily basis _____

OFFICE WORK

If your injury has occurred from office work only, please fill our the following:

☐ Sit at desk ☐ Walk ☐ Stand ☐ Stoop ☐ Hold ☐ Carry ☐ Other _____

Give percentage if applicable _____ Do you operate office machinery? ☐ Yes ☐ No

If yes, what type? _____

If your work is at a desk, give specifics of job, computer, typewriter, business machines, phone, etc.

_____

If walking, where to and job classification _____

Do you carry anything or pick anything up? ☐ Yes ☐ No If yes, what? _____

PREVIOUS WORK HISTORY

Give a job description of services or work performed for each job classification or source of employment for the preceding ten (10) years.

1. _____
2. _____
3. _____
4. _____
5. _____

Was a pre-employment exam performed or required? ☐ Yes ☐ No

Date _____ Doctor _____ Place _____

Have you ever applied for Workers' Compensation benefits before? ☐ Yes ☐ No Date _____

Reason _____

Was there a time loss from work? ☐ Yes ☐ No From _____ To _____ Year _____

State the degree of recovery _____

Did you retain legal counsel for these injuries? ☐ Yes ☐ No If yes, give name and address

_____

PRESENT WORK HISTORY

What is the job classification of your normal job? _____

Were you performing your normal job? ☐ Yes ☐ No What shift were you working? _____

How long have you been at your present job? _____ Has there been a time loss or absenteeism caused from job injury? ☐ Yes ☐ No If yes, explain _____

Average work week _____ Hours _____ Days _____

JOB CONDITIONS

Type of building _____

Type of floor ☐ Rough ☐ Smooth ☐ Wood ☐ Concrete ☐ Steel ☐ Other _____

Type of windows ☐ Open ☐ Closed ☐ No windows

Type of ventilation in the building ☐ Blower ☐ A/C ☐ Heat ☐ Exhaust ☐ None ☐ Other _____

Type of lighting in the building ☐ Fluorescent ☐ Overhead ☐ On machine ☐ Other _____

Are you tired when you go home at night? □ Yes □ No

Do you have any outside jobs? □ Yes □ No If yes, what type? _____

Do you participate in any company-sponsored programs such as exercise, sports, etc.? □ Yes □ No

If yes, describe _____

Type of shop □ Union □Non-union

Has outside help been hired? □ Yes □ No If yes, why? _____

How many employees are in the plant? _____ How many employees per shift? _____

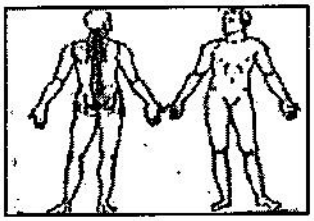
How many employees do your job? _____ What is the current injury ratio for that job? _____

How many employees have been injured doing your job? _____ Do you like your job? □ Yes □ No

If off work, do you want to return to your job? □ Yes □ No

What changes would you make in your job? _____

MARK PAIN AREA	
+++	BURNING
000	STABBING
---	SHARP
///	CONSTANT



_____ _____

Patient Signature Date

_____ _____

Staff Signature Date

* Click here to download First Report of Injury Form from Bureau of Workers Compensation website (scroll to bottom of page and click "Complete FROI".

New Patient Registration

So that we may best serve your healthcare needs, please complete the following information as accurately as possible. Thank you!

Today's Date _____/_____/_____

Legal Name _____

First Name you would like to be called:_____

Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ *Email Address:_____

* This will only be used to send email offers thru Constant Contact, office closings, special offers, Holidays, conditions we treat, etc. Also if you choose to have appointment reminders sent here.

Gender: Male Female **Marital Status**: Single Married Separated Divorced Widowed

Date of Birth _____ SS# _____ - _____ - _____ Age:_____

Emergency Contact: _____ Relationship_____
Phone: _____

What sources did you first utilize to choose our office? (Check all that apply)

1. Referred (name)_____ 2. Internet 3. Called Insurance 4. Angie's List

How you would like to receive appointment reminders: (check below)
□ Text message □ Phone (home/cell) □ Email □ None

*Employer _____ Occupation _____

Do you have health insurance you wish us to file? Yes___No___Have you seen another Chiropractor? Y / N

Name of Insurance Subscriber (policy card holder)_____ Subscriber's DOB: _____

Relationship to Subscriber _____ Subscriber's employer _____

Name of Primary Care Physician and City _____

Do you have a secondary insurance? Yes _____ No_____

_____ Date _____/_____/____
Signature of Patient (or Guardian if under 18)

Print Name _____ Date _____/_____/_____

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MEDICAL HISTORY

Patient Name_____

Main Complaints 1_____ 2_____ 3_____

_____

When did symptoms begin?_____What caused this condition?_____

If this is due to a **Personal Injury (auto accident) or **Worker's Compensation**, please notify front desk immediately.

General

- ◻ Poor Appetite
- ◻ Poor Sleep
- ◻ Waking at night
- ◻ When to bed:_____
- ◻ Tremors
- ◻ Cold back
- ◻ Night Sweats
- ◻ Poor coordination
- ◻ Strong thirst
- ◻ Heavy appetite
- ◻ Heavy sleep
- ◻ Trouble waking
- ◻ When to wake
- ◻ Vertigo
- ◻ Cold abdomen
- ◻ Sweat easily
- ◻ Sudden energy drop
- ◻ Bleeding/bruising easily
- ◻ Change in appetite: (how) _____
- ◻ Insomnia
- ◻Trouble going back to sleep
- ◻ Dreams
- ◻ Cold Hands
- ◻ Fevers
- ◻ Cravings
- ◻ Sudden increase in energy
- ◻ Best time of day_____
- ◻ Hours of sleep:
- ◻ Hours of sleep_____
- ◻ Fatigue
- ◻ Cold feet
- ◻ Chills
- ◻ Localized weakness
- ◻ Peculiar tastes/smells
- ◻ Worst time of day_____

Skin & Hair

- ◻ Dandruff
- ◻ Pimples
- ◻ Changes in hair/skin: _____
- ◻ Eczema
- ◻ Purpura
- ◻ Hives
- ◻ Rashes
- ◻ Other hair or skin problems: _____
- ◻ Itching
- ◻ Ulcerations

Head, Eyes, Ears, Nose & Throat

- ◻ Dizziness
- ◻ Poor hearing
- ◻ Eye pain
- ◻ Color blindness
- ◻ Sinus problems
- ◻ Copious saliva
- ◻ Grinding teeth
- ◻ Headaches
- ◻ Concussions
- ◻ Facial pain
- ◻ Poor vision
- ◻ Cataracts
- ◻ Mucus
- ◻ Teeth problems
- ◻ Sores on lips or tongue
- ◻ Other head or neck: _____
- ◻ Earaches
- ◻ Facial paralysis
- ◻ Blurry vision
- ◻ Spots in eyes
- ◻ Dry throat
- ◻ Gum problems
- ◻ Recurrent sore throats
- ◻ Ringing in ears
- ◻ Eye strain
- ◻ Night blindness
- ◻ Nosebleeds
- ◻ Dry mouth
- ◻ Jaw clicks
- ◻ Migraines

Cardiovascular

- ◻ High blood pressure
- ◻ Dizziness
- ◻ Blood clots
- ◻ Low blood pressure
- ◻ Fainting
- ◻ Phlebitis
- ◻ Chest pain
- ◻ Cold hands/feet
- ◻ Difficulty breathing
- ◻ Irregular heartbeat
- ◻ Swelling in hands/feet
- ◻ Other:_____

MEDICAL HISTORY

Patient Name_____

Respiratory

- ☐ Cough
- ☐ Coughing up blood
- ☐ Production of phlegm
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tight chest
- ☐ Difficulty when laying down
- ☐ Other lung problems: _____

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Gas
- ☐ Belching
- ☐ Constipation
- ☐ Bad Breath
- ☐ Rectal pain
- ☐ Black stools
- ☐ Sensitive abdomen
- ☐ Pain or cramps
- ☐ Bloody stools, odor
- ☐ Hemorrhoids
- ☐ Laxative use
- ☐ Undigested food

Genitourinary

- ☐ Pain with urination
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Unable to complete
- ☐ Dribbling
- ☐ STD
- ☐ Urinary tract infection
- ☐ Kidney stones
- ☐ Prostate problems
- ☐ Wake to urinate

Gynecology Pregnancy

- Age at first menses _____
- Pregnancies #_____
- ☐ Irregular Periods
- ☐ Menopause
- Last PAP _____
- Births #_____
- ☐ Painful periods
- ☐ Clots
- Last Menses_____
- Miscarriages
- ☐ Vaginal Discharge
- ☐ Breast lumps
- ☐ Birth Control
- Premature births_____
- ☐ Changes to body/psyche prior to menstruation

Neuropsychological

- ☐ Depression
- ☐ Areas of numbness
- ☐ Bad temper
- ☐ Concussion
- ☐ Treated for emotional problems
- ☐ Anxiety
- ☐ Considered/Attempted suicide
- ☐ Easily stressed
- ☐ Other: _____
- ☐ Poor memory
- ☐ Seizures

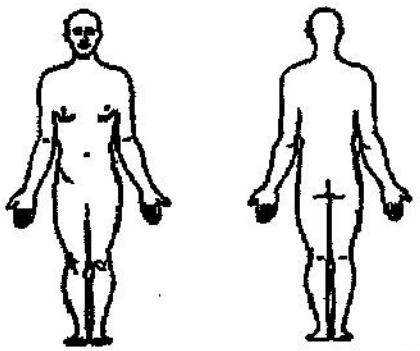
Musculoskeletal

- ☐ Neck pain
- ☐ Limb pain
- ☐ Back pain
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Better/worse with heat
- ☐ Better/worse with cold
- ☐ Better/worse with movement
- ☐ Better/worse with pressure
- ☐ Fixed location
- ☐ Sharp quality
- ☐ Dull quality
- ☐ Distending quality
- ☐ Radiating quality
- ☐ Burning quality
- ☐ Stabbing quality

Put a mark on the scale to indicate you present level of pain:

No Discomfort 1 2 3 4 5 6 7 8 9 10 Worst possible Discomfort

Mark location of pain or injury:



4/28/2020

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MEDICAL HISTORY

Patient Name_____

Significant Illnesses (list date of diagnosis)

◻ Cancer	◻ Diabetes	◻ High Blood Pressure	Other:_____
◻ Hepatitis	◻ Rheumatic Fever	◻ Thyroid Disease	_____
◻ HIV	◻ Heart Disease	◻ Seizures	_____

◻ Surgeries (type & date):

_____

_____

_____

◻ Significant Trauma (type and date):

_____

_____

Miscellaneous Information:

Birth History (prolonged labor, premature, forceps delivery, etc.):_____

Allergies (drugs, chemicals, food, etc.):_____

_____

_____

Medication (name and dosage, include vitamins and herbs): _____

_____

_____

Occupational Stresses (chemical, physical, psychological):_____

_____

_____

Exercise (type and frequency):_____

_____

Average daily diet (list morning, afternoon and evening):_____

_____

Family History

◻ Cancer	◻ Diabetes	◻ High Blood Pressure	◻ Allergies
◻ Stroke	◻ Seizures	◻ Asthma	◻ Heart disease
◻ Alcoholism	◻ Multiple sclerosis	Other: _____	

Notes (please add anything of note)

_____

_____

_____

_____

Terms of Acceptance

Patient Name: _____ **Date:** _____

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Dr.Julie B. Hilbert/Dr. Burton T. Young's office, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Consent to medical records submission:

Periodically medical records are requested by your insurance company and upon that request I agree to have all visit information sent.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one ☐

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes ☐ No ☐

Acknowledgement

☐ By subscribing my name below, I acknowledge my understanding and agreement to the notice of privacy practices (HIPAA effective as of 9/23/2013). I do NOT want a copy of my HIPAA laws at this time.

☐ By subscribing my name below, I acknowledge my understanding and agreement to the notice of privacy practices (HIPAA effective as of 9/23/2013). I have requested a copy of my HIPAA laws at this time.

Print Name: _____

Signature: _____ Date: _____

Financial Policy 2023

Payments/deductibles and/or co-payments are due at the time of service. A payment of $55.00 OR your Copay (if clearly marked on your insurance card) will be required at the time of service until we have verified your insurance. A current insurance card must be presented at the time service is provided. If charges are filed incorrectly due to outdated information, the complete balance then becomes your responsibility. Many of our families have Health Savings Accounts (HSA), or Health Reimbursement Accounts (HRA). You will be expected to pay at the time of service until your deductible is met. We accept cash, check, or any major credit card.

It is your responsibility to know the details of your insurance plan.

As a courtesy, we will verify your insurance coverage; however it is NOT a guarantee of benefits.

Please check which one of the following applies:

_____ **INSURANCE**
(□ **Check here for VA patients with active authorization)**
If your insurance is a high deductible plan, the office will collect in anticipation of your finalized claim. Once your Deductible has been met, your co-insurance will be collected each visit.

_____ **MEDICARE/Advantage Plans (See ABN form)**

_____ **MEDICAID (Molina/Caresource/Ohio Job and Family Services)**
If eligible, you must bring a current Medicaid card on the first visits and at the beginning of each month Thereafter when receiving treatment. Exams are not covered

_____ **WORKER'S COMPENSATION**
It is your responsibility to notify your employer and the doctor if you are seeking treatment from an injury sustained while on-the-job. This type of injury is classified as an Industrial injury and will be billed accordingly. If the injury neglects to meet the requirements of the Industrial Commission and they will not pay, you are responsible for all charges incurred in this office. If you have an established claim, please notify the receptionist that you need to sign a transfer of physician form.

_____ **PERSONAL INJURY**
We do not accept third-party payer. We do not bill the at-fault. Dr. Hilbert/Dr. Young recommends that you immediately file a claim with your automobile insurance. We bill med-pay first. When all med-pay funds have been used we will bill your health insurance. At the time of service you will be responsible for the deductibles, co-pays, etc. If you do not have health insurance or med pay, then you are responsible to pay as treatment is received on the day of each visit by cash, check, or credit card. Each case is unique so please do not hesitate to ask the receptionist. Ultimately, you are responsible for all charges incurred for treatment in our office.

_____ **NO INSURANCE COVERAGE**
Patient pays all fees on the day services are rendered by cash, check, or all major credit cards.

I hereby authorize any holder of medical information to release to my insurance company or intermediaries any information needed to process a claim for payment. I request that payment be made to Julie B. Hilbert, DC, Inc. for Any charges or services rendered to me by Julie B Hilbert, DC, FIAMA, Dipl.Ac. And/or Burton T Young, DC, FIAMA, Dipl.Ac. I understand I am financially responsible for any balance not covered. I agree to the terms in the Financial policy as stated above for the acupuncture and/or chiropractic care rendered to me by either of doctors Mentioned above. A late fee of $25 per month will be added to the balance, beginning at 90 days after service is rendered. Balances over 90 days past due will be forwarded to our collection agency.

_____ _____
Signature of Patient (Parent/Guardian) Date

_____ _____
Print Name of Patient (Parent/Guardian) Date

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2023 Massage Therapy Agreement

PAYMENT: Our office will verify your insurance benefits as a courtesy for you. However, a verification of benefits is never a guarantee of payment from the insurance company. For this reason, our office requires patients to sign a payment agreement to guarantee payment for their services. If for any reasons your insurance does not cover the services rendered, then you will be financially responsible for the entire amount owed to Dr. Hilbert and/or Dr. Young.

CHRONIC NO SHOW POLICY: This policy applies to all patients including VA or WC patients. If two appointments are missed, or less than 4-hour notice to cancel is given within a two-month period, then we will not be able to schedule, any future massage appointments in our office for the patient.

4-hour cancellation notice is required, or a fee will occur:
You must call or leave a message at the office at least 4 hours prior to your appointment to avoid a fee. If this notice is not given, then you will be charged a $40.00 missed appointment fee on your credit card the same day that the late/missed appointment occurs. Reminder calls are done as a courtesy; you are ultimately responsible for keeping your appointment. If you are running late, please call the office so that we may inform your massage therapist. There is no fee for being late; however, your massage time may be cut short due to the schedule. This policy does not apply to VA or WC patients.

By signing below, I agree to these terms:

_____ _____

Patient Signature Date

_____

Print Name

WEST CHESTER ACUPUNCTURE AND CHIROPRACTIC
DR. JULIE HIBERT AND DR. BURTON YOUNG
7665 MONARCH COURT, SUITE 110, WEST CHESTER, OHIO 45069
(PHONE) 513.777.9428 (FAX) 513.777.3628

Ohio | Bureau of Workers' Compensation

Notice to Change Physician of Record

The physician selected must be BWC certified or the injured worker will be responsible for payment.

Instructions for the injured worker
- Please complete all of Part I of the form.
- Sign in the space provided, and submit all copies to your managed care organization (MCO) to record your change of physician.

Part I

Injured worker's name	Date of injury	Claim number

Address	Phone number ( )

City	State	Nine-digit ZIP code

Please change my physician of record for the above listed claim as follows:

From physician	Provider number

Address	Phone number ( )

City	State	Nine-digit ZIP code

To physician	Provider number

Address	Phone number ( )

City	State	Nine-digit ZIP code

Reason for change

☐ Physician moved ☐ Physician no longer practicing ☐ I moved ☐ Physician is not a BWC-certified provider

☐ Physician terminated patient-provider relationship
Please explain: _____

☐ Dissatisfied with physician's treatment
Please explain: _____

☐ Other, please explain: _____

Have you been treated by the new physician for the condition(s) allowed in your claim? Yes☐ No☐ If yes give date of first treatment _____

Injured worker's signature	Date

Instructions for the MCO
- MCO to complete PART II.
- MCO must notify BWC via EDI (148) of change of physician within 24 hours of notification by the injured worker.
- Return signed copies per distribution listed below.

Part II

We have received and recorded your request for change of physician. You may bill only medical services and items related to the treatment of the allowed conditions and in accordance with the MCO medical-management guidelines to the MCO or the self-insured employer. The allowed conditions for this workers' compensation claim with corresponding ICD-9-CM codes are as follows: _____

MCO name	Phone number ( )

MCO case manager	Date

Distribution: White–MCO Claim file • Yellow–Injured worker • Pink–Requested physician • Goldenrod–Former physician

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 any 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 $ _____ Per: ☐ Hour ☐ Month ☐ Week ☐ 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 causally 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

BWC-1101 (Rev. 6/12/2014)
FROI-1 (Combines C-1, C-2, C-3, C-6, C-50, OD-1, OD-1-22)

This form meets OSHA 301 requirements