NY WCB WORKER'S COMP REGISTRATION

Today's Date: _____

Name: _____ DOB: _____ SSN#: _____

Gender: □ *Male* □ *Female* Marital Status: □ *Married* □ *Single* □ *Divorced*

Street Address: _____City: _____ State: ___ Zip Code: ____

Mobile phone: _____ Home phone: _____ Alternate phone: _____

Email: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Height: _____ Weight: _____

Do you smoke? □ *Yes* □ *No* If Yes, how much? _____

Do you consume alcohol? □ *Yes* □ *No* If Yes, how often? _____

Attorney Name: _____

Current Employment Status: □ *Full time* □ *Part time* □ *Retired* □ *Student* □ *Home maker*
□ *Unemployed* □ *Disabled* □ *Self-employed*

Most Recent Occupation: _____ Employer: _____

Employer Address: _____

Date of Injury: _____ Worker's Comp Insurer: _____

Adjuster Name: _____ Phone#: _____ Claim#: _____

Health Insurance Carrier: _____ Subscriber ID: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Describe the reason for today's visit in detail (how the injury incurred, where, when, ER visit, treatment at ER, out of work due to injury, any prior injury, etc):

_____

_____

_____

_____

_____

_____

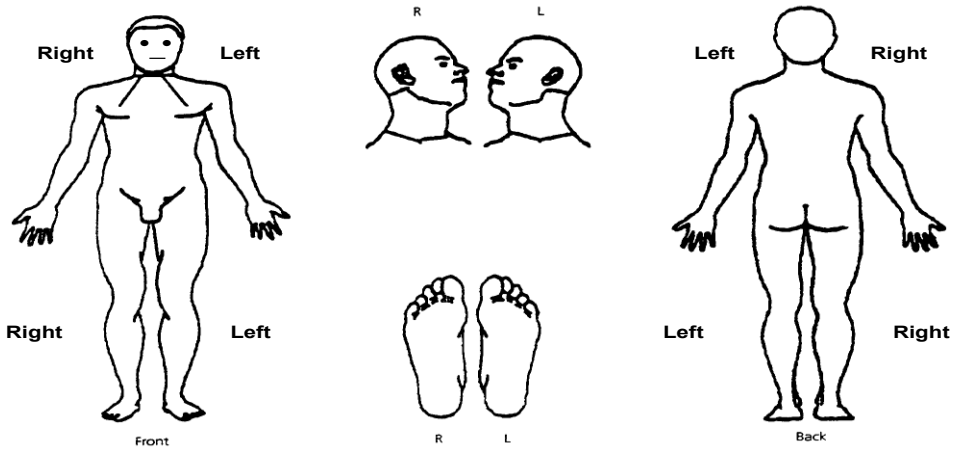
_____

_____

_____

Are you pain free prior to injury? [ ] Yes [ ] No

Location of Pain: Please shade in the painful areas in the diagram below. Put "x" on areas of tingling, "o" on burning areas, and "*" on areas with no feeling at all.



Least Pain level (0 being the least amount of pain): 0 1 2 3 4 5 6 7 8 9 10

Worst Pain level (0 being the least amount of pain): 0 1 2 3 4 5 6 7 8 9 10

Which of the following make your pain feel worse? Check all that apply.

□ *Sitting* □ *Standing* □ *Walking* □ *Lying down* □ *Bending forward* □ *Bending backwards*
□ *Morning hours* □ *Evening hours* □ *Coughing, Sneezing* □ *Damp weather*
□ *Physical therapy* □ *Getting out of bed* □ *Stress*□ *Other:*_____

Which of the following make your pain feel better? Check all that apply.

□ *Sitting* □ *Standing* □ *Walking* □ *Lying down* □ *Bending forward* □ *Bending backwards*
□ *Morning hours* □ *Evening hours* □ *Relaxation* □ *Physical therapy* □ *Acupuncture*
□ *Heat* □ *Ice pack* □ *Chiropractic treatment* □ *Other:*_____

Please list treatment and provider you had for your pain:

□ *Over the counter Pain Killer (such as Motrin, Advil, Aspirin, Aleve, Tylenol)*
□ *Chiropractic (How long? _____ Doctor/Facility? _____)*
□ *Physical Therapy (How Long? _____ Doctor/Facility? _____)*
□ *Acupuncture (How long? _____ Doctor/Facility? _____)*
□ *Surgery (What surgery? _____ Doctor/Facility? _____)*
□ *Pain Injections (such as epidurals, facet injections, joint injections, etc)*

□ *Other:* _____

Please check and list your past medical history: □ ***None***

□ *Heart Problem (Heart Attack, Stroke, CAD, Arrhythmia, Atrial Fibrillation, Stent, _____)*

□ *Hypertension* □ *High Cholesterol* □ *Diabetes* □ *Asthma* □ *Lung disease (COPD)* □ *Seizure*

□ *Hyperthyroidism* □ *Hypothyroidism* □ *GI disease (GERD)* □ *Kidney disease*

□ *Depression* □ *Anxiety Disorder* □ *Osteoarthritis* □ *Rheumatoid Arthritis* □ *Fibromyalgia*

□ *Migraine Headache* □ *Chronic Low Back Pain* □ *HIV* □ *Hepatitis B or C*

_____

_____

Primary Care Doctor Name: _____ Phone#: _____

Cardiologist (Heart) Name: _____ Phone#: _____

Neurologist (Seizure) Name: _____ Phone#: _____

Pulmonologist (Lung) Name:_____ Phone#: _____

Endocrinologist (Thyroid) Name: _____ Phone#: _____

Please check and list your past surgical history year: □ ***None***

□ *Back Surgery* □ *Neck Surgery* □ *Heart Surgery* □ *C-Section* □ *Eye Surgery*

_____

_____

_____

Do you have any allergies (food and medicine)? □ ***Yes*** □ ***No*** **If Yes, please list _____**

Please list MEDICATIONS with dosage and frequency you are taking: □ ***None***

_____

_____

_____

_____

_____

Are you taking blood thinners?

□ *Yes (□ Aspirin* □ *Plavix* □ *Coumadin/Warfarin* □ *Other_____)* □ *No*

Are you taking Benzodiazepine (i.e. valium, ativan, klonopin)?

□ *Yes* □ *No*

Note To Patients: For your safety, you MUST inform our providers ANY medication changes every time you see our providers.

Signature_____ Date_____

CONSENTS AND DISCLOSURE

Patient name: _____ Date: _____

ASSIGMENT OF BENEFITS AND INSURANCE AUTHORIZATION

I hereby authorize WeCare Medical Specialty Group to furnish information to insurance carriers concerning my illness and treatments and bill insurance carriers on behalf of me using my out of network benefit. I hereby assign all payments, for medical services rendered to myself or my dependent, unconditionally to WeCare Medical Specialty Group. I do understand that I am responsible for any amount not covered by my insurance and that should my insurance company send the payment to me, I will forward the payment within 48 hours to WeCare Medical Specialty Group.

Patient Signature:_____

CONSENT TO APPEAL AND ARBITRATION OF DENIAL

I hereby authorize WeCare Medical Specialty Group to file appeal and arbitration with my insurance carrier on behalf of me in case of denial of service and payment.

Patient Signature:_____

NO FAULT AND/OR WORKER'S COMPENSATION PATIENTS *ONLY*

I hereby authorize the release of my medical chart, bills and/or any other information related to my treatment, to my attorney _____. I further authorize WeCare Medical Specialty Group to pursue payment of my bills. I understand that all medical bills will be submitted to the responsible insurance carrier and will only be submitted to my medical insurance carrier in the event that payment is denied and/or there is remaining balance which I am responsible for. I understand that I am directly and fully responsible for all medical bills and if needed your attorney will arbitrate my bills for payment. I acknowledge that WeCare Medial Specialty Group and its providers do not accept Medicaid and do not bill Medicare for injury cases.

Patient Signature:_____

HIPPA PRIVACY ACKNOWLEDGEMENT

I acknowledge that I have been provided with a copy of WeCare Medical Specialty Group privacy notice, which is effective as of today's date.

Patient Signature:_____

DISCLOSURE

We wish to inform you that the doctor of WeCare Medical Specialty Group does have a financial interest in: *Surgicore Surgery Center*, *Manalapan Surgery Center, Union Surgery Center, and ICMISS*. You may, of course, choose to have your treatment at any of the health care facilities that we participate with.

Patient Signature:_____

CONTROLLED SUBSTANCE AGREEMENT AND INFOMED CONSENT

I acknowledge that I have been informed of WeCare Medical Specialty Group clinic policy and agreement on controlled substance and agree to abide the terms if I am placed on the controlled substances. Any violation of the clinic policy and agreement may cause termination of medication therapy at the discretion of my physician.

Patient Signature:_____

PATIENT AUTHORIZATION FORM

Patient Name: _____ DOB: _____

Claim#: _____

I hereby request and authorize my insurance carrier to release my insurance information and health record to WeCare Medical Specialty Group. The information includes but is not limited to:

1) **Medical Records**

I hereby also request and authorize my healthcare carrier, my treating physician and doctor, and lab to disclose, make available and furnish to WeCare Medical Specialty Group all information including: healthcare insurance, medical records, X-rays, MRI report, IME report and/or copies thereof related to my examination, confinement of treatment and to permit WeCare Medical Specialty Group to inspect and make copies, or abstracts thereof.

Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Please send the records by fax, mail or email to:

2040 Millburn Ave #201, Maplewood, NJ 07040
Phone: 973-996-2990 Fax: 908-242-3911
Email: officemanager@wecaremedical.us

I further understand this authorization is voluntary and that I may refuse to sign this authorization. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information to WeCare Medical Specialty Group.

Patient Signature: _____ Date: _____

Controlled Substance Agreement and Informed Consent Form
(please sign with your initial on each page)

The following agreement relates to my use of controlled substances including but not limited to "narcotics/opioids," to treat chronic pain. I will be provided with prescriptions only if I understand and agree to the following:

1. I understand that, depending on the drug and dose, I can become physically dependent on the medication and can develop withdrawal symptoms if the medication is stopped suddenly or the dose reduced rapidly. Although the risk is small there is a chance of developing an addiction to controlled substances if I am placed on them to help control my pain.

2. Controlled substances can cause sedation, confusion, or other changes in mental state and thinking abilities. I understand that the decision to drive while I am taking controlled substances is my own decision, and I agree not to be involved in any activity that may be dangerous to me or someone else such as driving or operating any dangerous equipment, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself if I am in any way sedated, feel drowsy or a not thinking clearly.

3. I will not use any illegal controlled substances including, but not limited to, marijuana and cocaine. I will not drive while intoxicated with alcohol.

4. The WeCare Medical Specialty Group policy regarding the dispensing of controlled substances requires that I be seen regularly and I agree to make and keep my appointments. I will advise my doctor of all other medicines and treatments that I am receiving.

5. If the medication requires adjustment, an appointment must be made to see the doctor. No adjustments will be made over the telephone. My careful planning is required. I understand that medication refills and adjustments are done during office appointments except under very unusual circumstances. I must stay with the prescribed dosing so that I do not run out of medication early. The medication is expected to last until the date that is found on the bottom of the prescription. I understand that the WeCare Medical Specialty Group policy is not to prescribe early. I agree that I will use my medication exactly as prescribed and that if I run out early, I may go without medication until the next prescription is due, possibly resulting in withdrawal symptoms.

6. I understand that the prescriptions are my responsibility once they are placed in my hand and that if anything happens to my prescription (lost, stolen, accidentally destroyed), I may not receive a replacement from my physician. WeCare Medical Specialty Group expects me to file a police report if my medication is stolen. I will be prepared to bring in a copy at my next office visit.

7. My physician will prescribe whatever medication he/she is comfortable with and thinks best; he/she is not under any obligation to prescribe any specific medication.

8. I am aware of the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other treatments discussed included: injections, therapy, and surgery (if indicated).

9. I agree to come to the WeCare Medical Specialty Group with my medication on the same day that I am called and submit to a pill count, and/or urine or blood screening to detect illegal substances or confirm proper use of prescribed medicine. The call to come to the WeCare Medical Specialty Group can be made either randomly, or if a concern arises. I may be required to bring my unused medication routinely to each office visit. If I do not have insurance or my insurance denies testing, I will be responsible for the cost of the test.

10. I give permission to the WeCare Medical Specialty Group staff to call any pharmacy or another health care provider at any time, without my being informed, to discuss my past or present use of controlled or illegal substances.

11. I will not use my pain medication in higher than prescribed amounts for new problems that arise (toothache, surgery, etc.) unless authorized to do so. I will inform my other doctor(s) of my use of medication for

chronic pain, and I will inform the WeCare Medical Specialty Group staff if another physician prescribes controlled substances for the acute problem. My doctor at WeCare Medical Specialty Group is my primary doctor with regard to my pain medications. If there is a medical emergency (e.g. broken leg, surgery requiring post-op pain medication, dental procedures, etc.), another doctor may prescribe pain medication to me, but I will advise the prescribing doctor of my care at WeCare Medical Specialty Group, authorize the doctor to disclose information to WeCare Medical Specialty Group, and I will also notify my doctor at WeCare Medical Specialty Group of the medication and dosage.

12. (Females only) Because of the risks of certain medications to unborn children, I will inform all physicians, obstetrician/ gynecologist and WeCare Medical Specialty Group, immediately if I become pregnant or decide to try to become pregnant. I am aware that should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon opioids. I am aware the use of opioids is not generally associated with risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

13. (Males only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

14. My physician can wean me off of controlled substances at any time if he/she feels that it is in my best interest. The weaning process can result in withdrawal symptoms. If I am weaned off, the WeCare Medical Specialty Group staff may inform my other health care providers as to the reasons for the weaning.

15. Abstinence Syndrome (Withdrawal Syndrome): Stopping my opioid, antiseizure or antidepressant medication abruptly may result in withdrawal symptoms (flu-like symptoms, GI distress, diarrhea, sweating, heart palpitations, and rarely seizures or death). I should wean from my medications rather than stopping them abruptly. If I find myself without medication, I will use the emergency line to notify my doctor.

16. I understand that in general I may be weaned off of my medication or my drug therapy may be terminated at the discretion of my physician if any of the following occur:a)It is the opinion of my physician that controlled substances are not very effective for my pain and/or my functional activity is not improved.b)I misuse the medication.c)I develop rapid tolerance or loss of effect from this treatment.d)I develop side effects that are significant and detrimental to me.e)I obtain controlled substances from sources other than my WeCare Medical Specialty Group physician without informing him or her.f)Pill counts or test results indicate the improper use of the prescribed medication or the use of other drugs, and/or I fail to submit to such counts/tests on the day that I am called.g)I am arrested and/or convicted for a controlled or illicit drug violation including drunk driving.h)Any violation of this agreement.

17. I further understand that my drug therapy will be terminated or detoxification in a controlled environment will be required if I give away, sell, distribute and/or transport with the intent to sell or dispense my medication.

18. I choose to use _____ Pharmacy, located at _____, for all of my pain medication prescriptions. I will not fill partial prescriptions, if my pharmacy does not stock the full quantity of medication. If I change my pharmacy for any reason, I agree to notify my pain physician.

I have read the above Agreement, understand the Agreement, have had all my questions concerning this Agreement answered to my satisfaction, and I agree to abide by the terms of this Agreement if I am placed on controlled substances (including, but not limited to narcotic analgesics). I have received a copy of the Agreement. By signing this form voluntarily, I give my consent for the treatment of my pain with narcotic/opioid pain medicines.

_____ _____

Patient Date

_____ _____

Physician Date

Your Rights and Protections Against Surprise Medical Bills

Federal No Surprises Act Disclosure Notice

When you receive emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from certain unexpected medical bills, also known as surprise bills.

What is balance billing?

When you receive care from a provider who does not participate in your health insurance network, that provider may ordinarily charge more than your insurance plan's allowed amount. The difference between the provider's charge and the amount paid by your insurance plan is called balance billing. Federal law prohibits balance billing in certain circumstances.

Your protections at an in-network surgical center

- You generally cannot be billed more than your applicable in-network deductible, copayment, or coinsurance for protected services.
- Your insurance plan must generally calculate your cost-sharing responsibility using the applicable in-network rules.
- Your out-of-network physician cannot bill you for the difference between the physician's charges and the amount paid by your insurance plan for protected services.
- You cannot be required to waive your federal balance-billing protections.

For certain nonemergency services, an out-of-network provider may request your written consent to waive these protections, subject to strict federal requirements. You are never required to give that consent.

Your rights under federal law

You are protected against prohibited balance billing under the No Surprises Act. If you believe you have been incorrectly billed, contact the Centers for Medicare & Medicaid Services (CMS) at 1-800-985-3059 or www.cms.gov/nosurprises.

For additional information about your rights under New Jersey law, you may also contact the New Jersey Department of Banking and Insurance.

This notice informs patients of their rights under federal law. It is not a waiver of those rights and does not authorize out-of-network balance billing.

NOTICE OF PRIVACY PRACTICES

Effective date: October 5th, 2026

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WeCare Medical Specialty Group ("WeCare," "we," "our") is required by law to maintain the privacy and security of your protected health information (PHI), to provide this notice of our legal duties and privacy practices, and to follow the terms of the notice currently in effect. We will notify affected individuals following a breach of unsecured PHI as required by law.

Your rights

Access your records

You may inspect or obtain an electronic or paper copy of medical and billing records and other PHI in our designated record set, subject to limited legal exceptions. We generally respond within 30 days; if a permitted extension is needed, we will notify you in writing. We may charge a reasonable, cost-based fee as permitted by law. You may also ask us to transmit an electronic copy to a designated third party where applicable.

Request corrections

You may ask us to amend information you believe is incorrect or incomplete. We generally respond within 60 days and will explain in writing if we deny the request. A permitted extension may apply.

Request confidential communications

You may request that we contact you by a particular method or at another address. We will accommodate reasonable requests without requiring you to explain your reason.

Request restrictions

You may ask us to limit uses or disclosures for treatment, payment, or health care operations. We generally are not required to agree, except that when you pay in full out of pocket for an item or service and request that we not disclose related information to your health plan for payment or health care operations, we must honor the restriction unless disclosure is required by law. Tell our Privacy Officer when requesting a restriction.

Accounting of disclosures

You may request an accounting of certain disclosures of your PHI made during the six years before your request, subject to exclusions under HIPAA. One accounting in any 12-month period is free; additional requests may incur a reasonable, cost-based fee.

Paper copy and personal representatives

You may request a paper copy of this notice even if you agreed to electronic delivery. A legally authorized personal representative may exercise your rights, subject to applicable law and verification of authority.

File a complaint

You may complain to our Privacy Officer or to the U.S. Department of Health and Human Services, Office for Civil Rights, at https://www.hhs.gov/hipaa/filing-a-complaint/ or 1-877-696-6775. We will not retaliate against you for filing a complaint.

Your choices and authorizations

You may tell us your preferences about sharing relevant information with family, friends, or others involved in your care or payment, and about disaster relief. If you cannot tell us your preference, we may share information when permitted by law and consistent with your best interests. WeCare does not operate a hospital patient directory; if that changes, applicable directory choices will be explained.

Except as otherwise permitted by law, we will obtain your written authorization for uses or disclosures for marketing, sale of PHI, and most uses or disclosures of psychotherapy notes. You may revoke an authorization in writing, except to the extent we have already acted in reliance on it. If we conduct fundraising communications, you may opt out of future fundraising contacts.

How we use and disclose health information

Treatment, payment, and health care operations

Treatment: We may share information with physicians, surgery centers, therapists, laboratories, and other professionals involved in your care, including referrals and care coordination.

Payment: We may share information with insurers, billing services, claims administrators, and other appropriate parties to determine coverage, obtain authorization, bill, collect payment, and address claims, appeals, and payment disputes.

Health care operations: We may use information for quality improvement, credentialing, audits, compliance, staff training, business management, and related lawful operations. Business associates handling PHI on our behalf are subject to required written safeguards.

Other uses and disclosures permitted or required by law

Subject to applicable legal conditions, we may use or disclose PHI for public health reporting; reporting abuse or neglect; health oversight; product safety and recalls; research; organ or tissue donation; coroners and funeral directors; workers' compensation; law enforcement and judicial proceedings; military or national security functions; correctional settings; averting a serious threat to health or safety; and other uses required by federal or state law. We may disclose PHI to HHS to demonstrate compliance with HIPAA. Some disclosures require additional safeguards, authorization, or legal process. New Jersey law may provide additional protections.

Specially protected substance-use-disorder records

WeCare does not operate a substance-use-disorder treatment program. However, if we receive or maintain patient records protected by 42 CFR Part 2 from another provider, we will comply with applicable additional restrictions. Such records may not be used or disclosed in civil, criminal, administrative, or legislative investigations or proceedings against the patient without the patient's specific written consent or an appropriate court order accompanied by required legal process, as permitted by Part 2. Other uses or redisclosures are subject to applicable Part 2 and HIPAA

requirements. If fundraising would use Part 2 information, we will provide any required advance notice and opportunity to opt out.

Our responsibilities and changes to this notice

We safeguard your information and notify you if a reportable breach of unsecured PHI occurs. We will not use or share information other than as described here unless you authorize it or the law allows or requires it. We may change this notice and apply the revised terms to PHI we already maintain. A current copy will be available at our office, on our website if applicable, and upon request.

Questions, requests, and complaints

Privacy Officer, WeCare Medical Specialty Group

Telephone: (973) 996-2990

Email: info@wecaremedical.us

Please contact the Privacy Officer to request records, amendments, restrictions, confidential communications, an accounting, or a paper copy of this notice.