LEMIRE, JOHNSON & HIGGINS, LLC

Attorneys at Law

2534 Route 9, P.O. Box 2485, Malta, NY 12020
518.899.5700 ~ 518.793.9005
Fax 518.899.5487
www.lemirejohnsonlaw.com

NEW CLIENT INTERVIEW SHEET

DATE: _____

1. NAME_____ REFERRED BY _____

2. ADDRESS_____ CITY_____
   ZIP CODE_____

3. DATE OF BIRTH_____ AGE_____

4. TELEPHONE (HOME) _____ (CELL)_____
   EMAIL_____

5. WCB#_____DATE/ACCIDENT_____SS#_____

6. EMPLOYER_____

7. EMPLOYER ADDRESS_____

8. DID YOU HAVE MORE THAN ONE JOB ON THE DATE OF ACCIDENT? If yes, list other employer(s):_____

9. COMPENSATION INSURANCE CARRIER _____

10. CARRIER ADDRESS_____

11. CARRIER CASE NUMBER_____

12. BRIEFLY DESCRIBE HOW INJURY OCCURRED_____
_____
_____

13. LIST ALL INJURIES_____

14. ARE YOU OUT OF WORK? Yes / No SINCE WHEN?_____

15. DATE, TIME AND PLACE OF NEXT HEARING_____

16. IF PRESENTLY REPRESENTED BY AN ATTORNEY, PLEASE PROVIDE THE NAME AND ADDRESS_____
_____

17. PLEASE PROVIDE REASON(S) FOR CHANGING ATTORNEYS_____
_____

** Please use the back of the form if you need additional space.

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

CHECK ONE ☐ NOTICE OF RETAINER AND APPEARANCE ☐ NOTICE OF SUBSTITUTION AND APPEARANCE
☐ NOTICE OF RETAINER AND APPEARANCE - ADDITIONAL ATTORNEY (For substitutions, item C MUST also be completed.)

WCB Case No.	Social Security No.	Date of Accident, Illness or Injury

	Name	Address
CLAIMANT		
EMPLOYER*		
CARRIER		
ATTORNEY OR REPRESENTATIVE	Lemire Johnson & Higgins, LLC	PO Box 2485, Malta, NY 12020

Representative's ID No., if any	Telephone No. of Atty/Rep.
R-501347	(518) 899-5700

*If claim is made under the Volunteer Firefighters' Benefit Law or the Volunteer Ambulance Workers' Benefit Law, show as EMPLOYER the liable political subdivision and enter "X" in the appropriate box..... ☐ VFBL ☐ VAWBL

A. CLAIMANT COMPLETE THIS SECTION

CHECK ONE:

☐ Please take notice that I have retained the above-named firm/individual to represent me in all proceedings concerning my claim.

☐ Please take notice that I have retained the above-named firm/individual to represent me in my appeal to the Supreme Court, Appellate Division, Third Department, or the Court of Appeals.

☐ Please take notice that in place of _____ I have retained the above-named to represent and appear for me in all proceedings concerning my claim.

My claim is under the ☐ Workers' Compensation Law ☐ Volunteer Firefighters' Benefit Law ☐ Volunteer Ambulance Workers' Benefit Law ☐ Disability Benefits Law ☐ Section 120/241 WCL - Discharge or Discrimination Complaint

I hereby authorize the above-named attorney/representative to request and obtain copies of any necessary medical records connected with the Workers' Compensation Board (WCB) case indicated above. In addition, I consent to the transmittal of all medical reports in this case from my health provider(s) to my attorney/representative. I understand and agree that a licensed representative may appear on my behalf at the request of my attorney.

In addition to the case folder for this claim, I authorize the above-named attorney/representative to access (check ONE):

☐ All of my workers' compensation case files maintained by the NYS WCB.
☐ The following workers' compensation case file(s) maintained by the NYS WCB (list by number): _____
☐ No other access permitted.

Claimant's Signature _____ Date _____

B. ATTORNEY/REPRESENTATIVE COMPLETE THIS SECTION

I agree to represent the above-named claimant in compliance with the aforementioned Law and Rules and Regulations promulgated thereunder and hereby notice my retention in the above case. All notices, decisions and other documents are to be sent to the undersigned unless otherwise indicated below. It is understood that the only fees to be paid in this case are those fixed by the WC Law Judge, the Board, the Conciliator or designated employee of the Chair.

I am (CHECK ONE):

☐ An Attorney at Law ☐ A Licensed Representative with Fee–License No._____ ☐ A Licensed Representative without Fee--License No._____

Signature of Attorney/Representative _____ Date _____

ATTORNEY OR REPRESENTATIVE WHO IS TO APPEAR, IF OTHER THAN YOURSELF

Name_____ Address_____ Tel.No._____ will appear in this case. All notices, decisions and other documents should be sent to (him, her or them). Fees, if any should be made payable to:

Name_____ Address_____ Tel. No._____

C. FOR SUBSTITUTION ONLY - ATTORNEY/REPRESENTATIVE COMPLETE THIS SECTION

A copy of this notice of substitution was served on the _____ day of _____, 20_____, on

_____ _____
Name of Former Attorney or Representative Address

D. REQUEST AND NOTICE TO HEALTH PROVIDER

Pursuant to Section 13(f) of the Workers' Compensation Law, please transmit copies of all your medical reports to me as the claimant's representative.

Signature of Attorney or Representative appearing for claimant _____

Please Note: A photocopy of this notice shall be deemed as effective as an original.

E. CERTIFICATION OF TRANSMITTAL OF THIS NOTICE TO INSURANCE CARRIER/SELF-INSURED EMPLOYER

I hereby certify that a copy of this notice was transmitted to the insurance carrier or self-insured employer named above at the time of filing with the Board.

_____ _____
Signature of Attorney or Representative Date

NOTICE TO ATTORNEY OR REPRESENTATIVE:

1. This form may be used by an **original, substituted or additional** attorney or representative. Check appropriate box on top of form.
2. Send a copy of this form to **all** of the claimant's health providers.
3. A copy of this form **must** be sent to the workers' compensation insurance carrier or self-insured employer.

Employee Claim

C-3

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 / City / State / Zip Code)

4. Social Security Number: ___ - ___ - ____ 5. Phone Number: (____)_____ 6. Gender: ☐ Male ☐ Female

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): _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

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. Do you remember having 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 he or she is 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: ____/____/____

Limited Release of Health Information (HIPAA)

State of New York - Workers' Compensation Board

C-3.3

WCB Case No. *(if you know it)*:_____

To Claimant: If you received treatment for a *previous* injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your previous injury/illness to your employer's workers' compensation insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) says you have a right to get a copy of this form. If you do not understand this form, talk to your legal representative. If you do not have a legal representative, the Advocate for Injured Workers at the Workers' Compensation Board can help you. Call: 800-580-6665.

To Health Care Provider: A **copy** of this HIPAA-compliant release allows you to disclose health information. If you send records to the employer's workers' compensation insurer in response to this release, also mail copies to the Claimant's legal representative. (If no legal representative is listed below, send copies to the Claimant.) Health care providers who release records must follow New York state law and HIPAA.

This release is:

- **Voluntary.** Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- **Limited.** It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- **Temporary.** It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- **Revocable.** You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's workers' compensation insurer and the Workers' Compensation Board. *Note: You may not cancel this release with respect to medical records already provided.*
- **For records only.** It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's workers' compensation insurer.

This form does NOT allow your health care provider(s) to release the following types of information:

- **HIV-related information**
- **Psychotherapy notes**
- **Alcohol/Drug treatment**
- **Mental Health treatment** (unless you check below)
- **Verbal information** (your health care providers may not discuss your health care information with anyone)

Any medical records released will become part of your workers' compensation file and are confidential under the Workers' Compensation Law.

A. YOUR INFORMATION (Claimant)

1. Name:_____ 2. Social Security Number:___-___-____
3. Mailing Address: _____
4. Date of Birth: ___/___/___ 5. Date of the current injury/illness: ___/___/___
6. Current injury/illness, including all body parts injured:_____
7. Your legal representative's name and address (if any):_____

☐ *Check here if you allow your health care provider(s) to release* ***mental health care*** *information.*

B. YOUR HEALTH CARE PROVIDER(S)

(List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers attach their contact information to this form.)

1. Provider:_____ 2. Phone Number: (___)_____
3. Mailing Address: _____
4. Other provider (if any):_____ 5. Phone Number: (___)_____
6. Mailing Address:_____

C. READ AND SIGN BELOW.

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

_____

Claimant's signature (ink only -- use blue ballpoint pen, if possible.) Date

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below:

_____

Your name | Relationship to Claimant | Signature (ink only -- use blue ballpoint pen, if possible.) | Date

Versión en español al reverso de la forma.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Address: _____ **Phone No:** _____
_____ **SS#:** _____

TO: _____
_____
_____

1. I, _____ authorize the disclosure of my protected health information as described below.

2. The type and amount of information to be disclosed is as follows:

All records: **(Please initial appropriate line(s) and/or indicate date(s) if you wish to limit authorization)**

____ Entire Record
____ Most recent history and physical, Dates of Service: _____
____ Most recent discharge summary
____ Laboratory results
____ X-rays and imaging reports
____ Consultation reports
____ Problem list
____ Medication list
____ List of Allergies
____ Immunization record
____ Other _____

3. This information may be disclosed to and used by: **Lemire Johnson & Higgins, LLC**
Attorneys at Law
2534 Route 9, PO Box 2485
Malta, NY 12020

4. Purpose of disclosure: ____ Workers' Comp. ____ Personal
(Please initial) ____ Insurance ____ Medical ____ Other: _____

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will no apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire five (5) years from the date I have signed it.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by the federal confidentiality rules.

7. You may accept a photocopy of this authorization and treat it as though it were an original signed by me.

_____
Print Name

_____ _____
Signature **Date**

DOWNSTATE CENTRALIZED MAILING
(for New York City, Hempstead, Hauppauge & Peekskill Districts)
PO Box 5205 Binghamton, NY 13902-5205
NYC (800)877-1373 / Hemp. (866)805-3630 / Haup. (866)681-5354 / Peek. (866)746-0552

100 Broadway Menands ALBANY 12241 (866) 750-5157
State Office Building 44 Hawley Street BINGHAMTON 13901 (866) 802-3604
295 Main Street Suite 400 BUFFALO 14203 (866) 211-0645
130 Main Street W. ROCHESTER 14614 (866) 211-0644
935 James St. SYRACUSE 13203 (866) 802-3730

State of New York
WORKERS' COMPENSATION BOARD

CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

(Pursuant to Workers' Compensation Law Section 110-a)

PLEASE COMPLETE ALL ITEMS. AN INCOMPLETE FORM WILL DELAY THE PROCESSING OF YOUR REQUEST.

Claimant's Name	Claimant's Social Security No.	Case Number ☐WCB ☐DB ☐Discrimination and/or Date of Accident

IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC CASE NUMBER AND/OR DATE OF ACCIDENT(S).

CLAIMANT IS PROHIBITED FROM AUTHORIZING RELEASE OF WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT.

INSTRUCTIONS:

Submit original to the Workers' Compensation Board and retain a copy for your records. *Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form.* This authorization is effective until it is revoked by the claimant. Claimant may revoke this authorization at any time upon written notice to the Workers' Compensation Board.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO OPEN AN INDIVIDUAL eCASE ACCOUNT OR TO VIEW CASES VIA eCASE OUTSIDE OF A BOARD LOCATION.

Pursuant to Section 110-a of the Workers' Compensation Law, I, _____,
Claimant's Name

represent that I am a person who is/was the subject of the Workers' Compensation case(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to

Lemire Johnson & Higgins, LLC, at
Name of a Specific Person, Corporation, Association or Public or Private Entity

2534 Route 9, P.O. Box 2485, Malta, NY 12020.
Address

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

_____ _____
Claimant's Signature (ink only -- use blue ballpoint pen if possible) Date

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.