PHYSICIAN'S REPORT

Alaska Department of Labor
Alaska Workers' Compensation Board
P.O. Box 25512, Juneau, Alaska 99802-5512

☐ **INITIAL** Employee: Sections 1 & 2/Physician: Sections 3 & 4
☐ **PROGRESS** Physician: Sections 1 & 4
☐ **TREATMENT PLAN** Employee: Sections 1 & 2/Physician: Sections 3 & 4

AWCB Case Number

SECTION 1

1. Employee's Name (Last, First, Middle Initial)
2. Insurer Claim Number
3. Injury Date
4. Address
5. Sex ☐ Male ☐ Female
6. Social Security Number
City State Zip Code Telephone
7. Birthdate
8. Employer
9. Insurer
10. Address
11. Address
City State Zip Code Telephone
City State Zip Code Telephone

SECTION 2

12. Date Last Worked
13. Was Body Part Injured Before? ☐ No ☐ Yes If yes, when and describe:
14. Describe Injury and Tell How it Happened:
15. Have You Seen any Other Doctor for this Injury? ☐ No ☐ Yes If yes, list name and address:
16. Hospitalized as Inpatient? ☐ No ☐ Yes Name of Hospital:

SECTION 3

17. YOUR First Treatment Date:
18. Describe Complaints:
19. Fully Describe Findings on First Examination (Specify Right or Left):
20. Diagnosis
21. X-Rays? ☐ No ☐ Yes X-Ray Diagnosis:
22. Is Condition Work Related? ☐ No ☐ Yes Explain: ☐ Undetermined (Explain):

SECTION 4

23. Treatment Date(s) Since Last Report:
24. Next Treatment Date:
25. Estimate Length of Further Treatment Days Weeks Months
26. Medically Stable? ☐ No ☐ Yes
27. Date of Medical Stability
28. Injury May Permanently Preclude Return to Job at Time of Injury ☐ No ☐ Yes ☐ Undetermined
29. Will Injury Result in Permanent Impairment? ☐ No ☐ Yes ☐ Undetermined
30. Impairment Rating:
31. Factors on Which Rating is Based:
32. Released for Work ☐ No Estimate Length of Disability: ☐ 1-3 Days ☐ 4-7 Days ☐ 8-14 Days ☐ 15-21 Days ☐ 22-28 Days ☐ More: _____ Weeks _____ Months
☐ Yes ☐ Regular Work (date): ☐ Modified Work (date): Give Limitations:
33. If the number of treatments will exceed Board's frequency standards, state the objectives, modalities, frequency of treatment, and reasons for frequency of treatments. Continue treatment plan on reverse if necessary. GIVE EMPLOYEE AND EMPLOYER/INSURER A COPY OF THIS REPORT.
34. Describe Treatment (and/or Attach Chart Notes):
35. If Case Referred to Another Physician, State Name and Address:
36. IRS I.D. Number
37. Physician's Name and Degree (Print or Type)
38. Physician's Signature
39. Report Date
40. Address City State Zip Code
41. Telephone

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Active Health Solutions

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OFFICE (907) 349-5552 | Chiropractic, Active Release Technique, Sports Therapy | FAX (907) 349-5100

DOCTOR'S LIEN

TO: Insurance Carrier / Attorney

_____

_____

DOCTOR: _____

RE: Patient Records and Doctor's Lien

_____

I DO HEREBY AUTHORIZE the above doctor to furnish you, my insurance carrier/attorney, with information regarding my history, examination, diagnosis, treatment and prognosis of myself with regard to my accident/injury which occurred/began on _____.

I do hereby give a lien to the above mentioned doctor on any settlement, claim, judgment, or verdict as a result of said accident/injury, and authorize and direct you, my insurance carrier/attorney, to pay directly to said doctor such sums as may be due and owing for services rendered me.

I fully understand that I am directly responsible to said doctor for all bills submitted for services rendered to me, and that this agreement is made solely for said doctor's additional protection and in consideration of awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover.

Dated: _____ Patient's Signature: _____

ACKNOWLEDGEMENT OF DOCTOR'S LIEN

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient, does acknowledge receipt of the above lien, and does agree to honor the same to protect said above named doctor.

Dated: _____ Authorized Signature: _____

*****Please date, sign and return to doctor's office at once. Keep a copy for your records.**

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NOTICE TO INSURANCE COMPANY

OF ASSIGNMENT

TO: _____

_____

_____

You are instructed to pay direct to the doctor at his/her office for all professional services rendered to me.

This instruction to you is an ASSIGNMENT OF RIGHTS under my medical coverage to the extent of this bill.

Any sum of money paid under this assignment shall be credited to my account and I shall be personally liable for any unpaid balance.

PATIENT NAME: _____

PATIENT SIGNATURE: _____

PATIENT ADDRESS: _____

DATE: _____

ACKNOWLEDGEMENT OF INSURANCE COMPANY

This insurance company hereby acknowledges receipt of the above ASSIGNMENT OF BENEFITS and agrees to forward payment of medical services rendered. Payment will be sent to the office of and to the order of the doctor only.

AUTHORIZED SIGNATURE: _____

DATE: _____

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FINANCIAL POLICY:
WORKER'S COMPENSATION

For those patients who have been injured on the job:

You are covered under the State of Alaska Workers Compensation law. This law provides you with 100% chiropractic coverage for work-related bodily injuries.

Our office will submit the medical injury forms and submit all bills directly to the insurance carrier of your employer.

However, in order for us to ensure effective coverage, you must do the following:

1. Report the injury to your supervisor immediately.

2. Fill out an employee work injury form and turn into your employer. Once completed, your employer should give you a green and yellow copy.

3. Fill out the top two sections of the yellow form (Physicians Report) we present to you. This must be completed at our office to ensure that we submit this in a timely manner.

4. Read carefully the pamphlet "Worker's Compensation and You" (available at http://labor.state.ak.us/wc/wc-brochure.pdf) Your understanding of what your legal rights are in regard to your injury will enable us to all work together to get you better and back to work.

By my signature, I **clearly understand** and agree that I am ultimately responsible for all services rendered to me.

PATIENT SIGNATURE:_____ DATE:_____

WITNESS SIGNATURE:_____ DATE:_____

ART Active Release Techniques ®

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WORKERS COMPENSATION HISTORY

NAME_____

PREVIOUS WORK HISTORY:
Give a detailed description of services or work performed for each source of employment for the preceding 10 years._____

_____

_____

_____

Was a pre-employment exam performed or required? □Yes □No
Date: _____ Doctor/Place: _____
Have you ever applied for worker's compensation benefits before? □Yes □No
Date: _____ Reason: _____
What was the time loss from work? _____
State the degree of recovery for each: _____

_____

Have you retained any legal counsel for this injury? □Yes □No For a previous injury? □Yes □No

PRESENT INJURY
Date present injury was received:_____What is job classification of normal job?_____
Were you doing a normal job duty? □Yes □No How long have you been at present job? _____
What shift were you working? _____ Time of accident? _____
Were you on overtime? □Yes □No
Average work week? Hours:_____ Days:_____
Who saw the accident? Name:_____ Title: _____
Name:_____ Title: _____
Who reported the accident? Name:_____ Title: _____
Name:_____ Title: _____
What medical attention was rendered? □Yes □No
By Whom? □Nurse:_____ □M.D._____
□D.C.:_____ □Other:_____

INJURY DESCRIPTION
How did the injury occur?_____

_____

Chief complaints (symptoms): _____
If working on a machine, give the size (height/weight/length):_____
Foot or hand levers?_____ Did you work overhead? □Yes □No Straight on or under?_____
Movements on the job – were they to the right, left, up, down, under, over? _____

_____

Did you pick up or lift? □Yes □No If you lift, how much?_____How often do you lift?_____
From where, in what, to where?_____
Do you lift from the ground, bench, platform?_____
Pallet, box or other? (Please describe)_____
Do you lift out of a machine?_____

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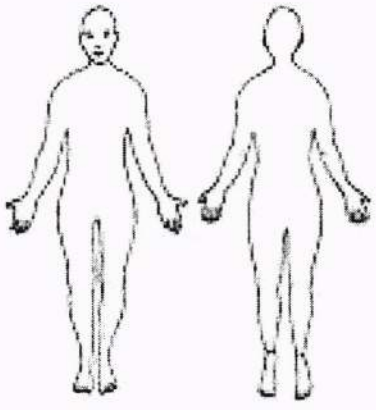
If working at a machine, do you? □Sit □Stand □Kneel
If so, onto what?_____ Is the work area cluttered?_____
If so, with what?_____
Is the work area? □Oily □Dirty □Slippery
In your job do you push or pull? □Yes □No If yes, give specifics:_____
_____
Do you use a cart? □Two-wheel □Four-wheel
Construction of cart_____
Type of wheels? □Rubber □Steel □Plastic
Repair of cart:_____
Number of carts being pushed or pulled at one time?_____
The total amount of weight being pushed or pulled on a daily basis?_____

JOB CONDITIONS
Type of building:_____
Type of floor: □Rough □Smooth □Wood □Concrete □Steel
Type of windows:_____Type of ventilation in the building:_____
Type of lighting in the building:_____
Are you tired when you go home at night? □Yes □No
Do you have outside jobs? □Yes □No Describe:_____
Do you participate in a company sponsored program such as exercise, sports, etc? □Yes □No
Is it a union shop or a non-union shop?_____
Have you had to hire outside help? (ie. Cleaning, grass cutting, maintenance?) □Yes □No _____
How many employess in the plant?_____How many employees per shift?_____
How many other employees do your job?_____ What is the injury ratio for that 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?_____
_____

OFFICE WORK:
Do you… □Sit at desk □Walk □Stand □Other_____
What % of each? _____
Do you stand, stoop, hold, carry, etc? Describe. _____
Do you operate other machinery? □Yes □No If yes, what type?_____



Mark area of pain in drawing. Use following codes:
++++ (Burning pain), 0000 (Stabbing pain), - - - (Sharp pain), I I I (Constant pain)

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Employee's Name _____

Address _____

City/State Zip _____

Telephone _____

SSN _____ DOB _____ Male or Female _____

Employer _____

Employer Address _____

City/State/Zip _____

Employer Telephone _____

Insurer _____

Insurer's Address _____

City/State Zip _____

Telephone _____

Date of injury _____ Insurer Claim Number _____

Date last worked _____

Was body part injured before? If yes, describe: _____

_____

Describe injury and tell how it happened: _____

_____

_____

_____

Have you seen another doctor for this injury? If yes, whom: _____

Were you hospitalized as inpatient? If yes, what hospital: _____

_____