PHYSICIAN'S REPORT

ALASKA DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT
Alaska Workers' Compensation Board
P.O. Box 115512, Juneau AK 99811-5512

◯ **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. Date of Injury
4. Address				5. Sex ◯ Male ◯ Female	6. Social Security Number
City	State	Zip Code	Telephone		7. Date of Birth
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 ◯ Yes ◯ Regular Work (Date): Estimate Length of Disability ◯ 1-3 Days ◯ 4-7 Days ◯ 8-14 Days ◯ 15-21 Days ◯ 22-28 Days ◯ More ____ Weeks ____ Months ◯ 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 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

SEE INSTRUCTIONS ON BACK

INSTRUCTIONS TO PHYSICIANS:

1. Clearly mark on reverse whether you are making an Initial, Treatment Plan, or Progress Report.
2. When making an Initial Report or Treatment Plan Report, ask employee to complete Sections 1 and 2. You should complete Sections 3 and 4.
3. When making a Progress Report, complete Items 1, 3, 6, 7, 8 and 9 of Section 1 (you may complete additional items for your own convenience) and Section 4.
4. A Treatment Plan IS REQUIRED ONLY if you treat the injured worker MORE OFTEN than provided in the following chart:

1st MONTH	2nd & 3rd MONTHS	4th & 5th MONTHS	6th THRU 12th MONTH
3 treatments per week	2 treatments per week	1 treatment per week	1 treatment per month

5. Within 14 days after each treatment, send the ORIGINAL report to the Alaska Workers' Compensation Board, and a copy to the employer/ insurer. If you treat the employee more frequently than once every 14 days, you may report all treatments during a 14-day period on one form.
6. Send your billing only to the employer/insurer; the Board does not pay medical expenses.
7. If you need more space than that provided on the front of the form, use the space below.
8. You may make copies of this form. The Board will provide supplies of this form on request.
9. Late or incomplete reporting may delay the employee's compensation payments. The employer/insurer may not be required to pay your treatment if reports are not submitted timely.

INSTRUCTIONS TO EMPLOYEE:

1. Complete Sections 1 and 2 of the Initial Report.
2. The report is NOT a substitute for your written notice of injury to your employer and the Alaska Workers' Compensation Board. If you have not already done so, immediately contact your employer and complete Items 1 through 17 of the Report of Occupational Injury or Illness (Form 07-6101).

42. Employee's Name (Last, First, Middle Initial)	43. Report Date
44. REMARKS (or Treatment Plan continued)	

Medical records in an employee's file maintained by the board are not public records subject to public inspection and copying under AS 09.25.

Chugach Chiropractic Clinic LLC

11462 Business Boulevard, Eagle River, Alaska 99577
(907) 694-9224 ◆ Fax: (907) 694-1066
www.careforyourspine.com

Receipt of Notice of Privacy Practices

I have had an opportunity to review the Notice of Privacy Practices.

Patient's Printed Name	Date of Birth
Patient's Signature or that of Legal Representative	Today's Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Individual

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Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____