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Workers'Compensation Information

Patient Information

Name: _____ Birthdate: _____ SS#: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell: _____ Work: _____
E-Mail Address: _____
Occupation: _____ Sex: Male/Female Marital Status: _____
Height: _____ Weight: _____ B/P(Office Use): _____ Pulse(Office Use): _____

Employer Information

Employer Name: _____ Address: _____
_____ City: _____ State: _____ Zip: _____
Contact Person: _____ Injury Verified By: HD/JG/TR/BM/MZ
Contact's Phone Number: _____ Fax: _____

Workers' Compensation Carrier (For Office Use)

Workers' Compensation Carrier: _____ Compensable Injury Below
Carrier Address: _____ _____
City: _____ State: _____ Zip: _____ Verified: HD/JG/TR/BM/MZ
Carrier Phone Number: _____ Fax: _____
Adjuster: _____ Ext: _____ Claim#: _____
Did the employer sign with a network? Y/N If so, who? _____
Pre-Auth Carrier _____ Ph. _____ Fx. _____

Injury Information

Date of Injury: _____ Day: _____ Time: _____am/pm Date of Hire: _____
Place of Injury (Location & Department): _____
Was injury reported to your employer? Yes/No Have you lost time from work? Yes/No
How many days have you missed? _____ What dates were missed? _____
Name of person you reported your injury to: _____ (Supervisor/Manager?)
Give full description of how you were injured: _____
_____
_____
Gross Wages$: _____ Hourly$: _____ Weekly or biweekly$: _____
Areas of your body that were injured: _____
Other doctors seen for this injury: _____
Phone Number: _____ Were X-Rays taken? Yes/No Other Tests? Yes/No
Name of witness that saw your injury: _____
Have you changed doctors before for this injury? Yes/ No If yes, what date: _____
Any previous workers' compensation injuries? Yes/No If yes, dates of injuries: _____
Describe previous workers' compensation injuries: _____
_____

Authorization

Nearest Relative: _____ Relationship: _____ Phone: _____
Patient Signature: _____ Date: _____

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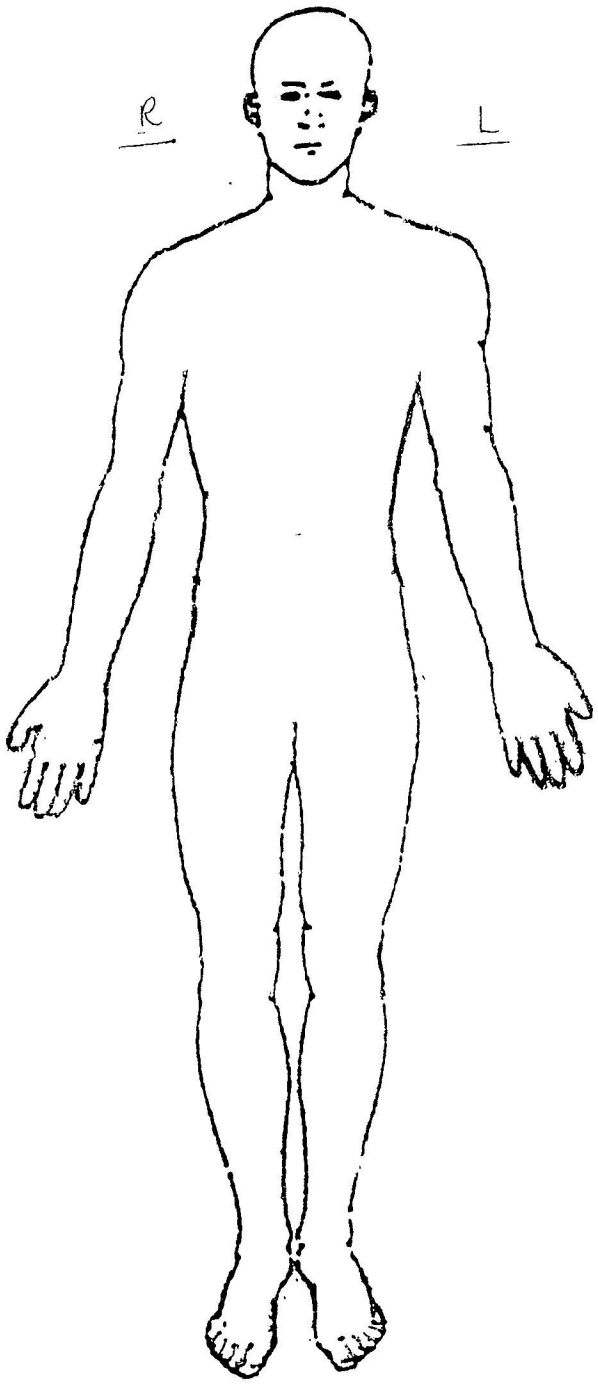
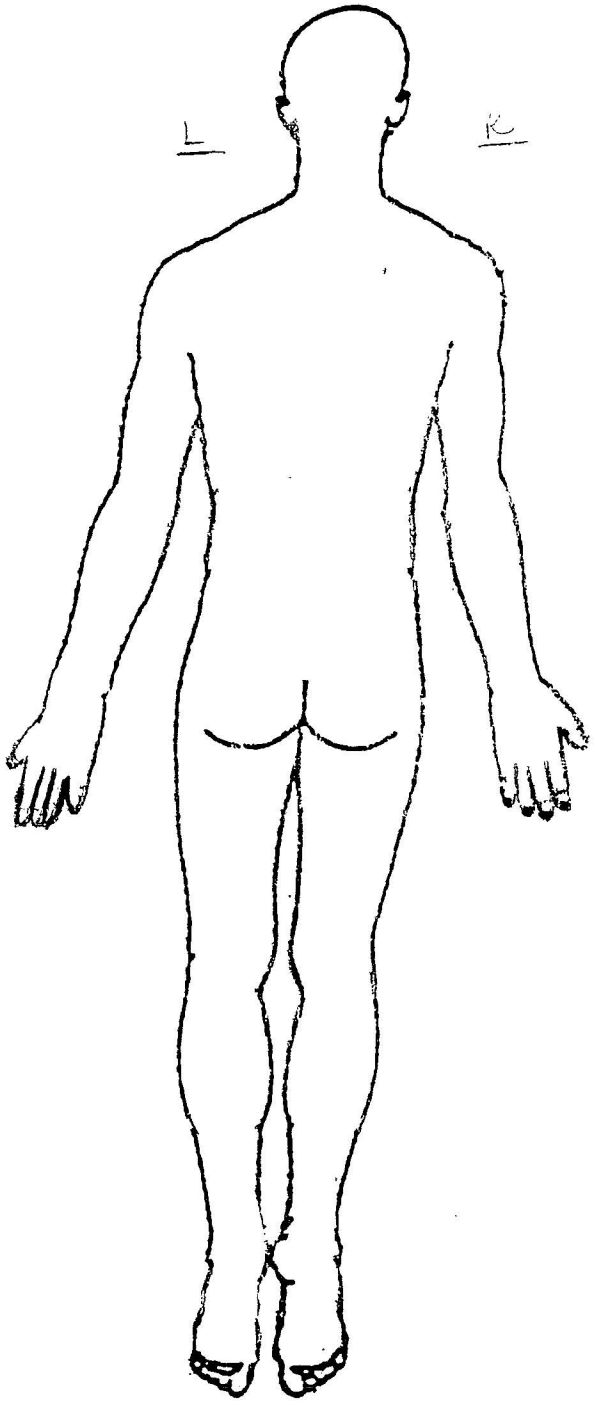
Patient Name: _____ Date: _____

Put a **"X"** or a **"Circle"** where your pain is. Thank You!



FRONT SIDE



BACK SIDE

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HIPAA Declaration

The Practice:

(a) Is required by federal law to maintain the privacy of your Protected Health Information and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your Protected Health Information.

(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your Protected Health Information than that which is provided for under federal law

(c) Is required to abide by the terms of the Privacy Notice

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your Protected Health Information that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation

(f) Will not retaliate against you for filing a complaint

EFFECTIVE DATE

This Notice is in effect as of 7/26/04

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of this notice, and my understanding and my agreement to its terms.

_____
PATIENT

_____
DATE

FOR PRACTICE USE ONLY

Practice Documentation of Good Faith Effort to Obtain Acknowledgment
Patient's acknowledgment of this notice could not be obtained because:

__Patient refused to sign
__Communication barrier prohibited obtaining acknowledgment
__Emergency circumstances
__Other
Details:

_____
Signature of Practice

_____
Date