

## **WORKMAN'S COMPENSATION PATIENTS**

The following information is necessary for claims processing:

- >Name, address and phone number of where to send claims to.
- >Insurance claim number from your employer's insurance company
- >Contact person at your place of employment.
- >Case worker's name and phone number.

**PATIENT/PHYSICIAN CONTRACT**

I hereby authorize Acu-Care Total Health and/or its agents or employees to contact my insurer or other responsible third party to confirm my eligibility for reimbursement for services provided by this office. I understand and agree that the medical necessity and fees due for all services provided to me by this office will be determined by Acu-Care Total Health, and that payment in full for all such services is my own responsibility, regardless of any reimbursement arrangements between myself and any insurance plan or other third party involved in payments for my case. I authorize any such insurance plan or other third party to pay benefits directly to this office when a balance is due. I agree to remit directly to this office immediately upon request, any and all amounts due, and will be responsible for attorney's fees equal to one third of the outstanding balance due should legal collection proceedings be initiated to ensure my full compliance with this agreement. I further agree that, should I discontinue care on my own, I will be responsible for payment in full, any charges due Acu-care Total Health. I certify that all of the above information is current, true and correct to the best of my knowledge, and I will notify this office immediately of any changes in my health status or financial information.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**ACCIDENT AND INJURY QUESTIONNAIRE AND ASSIGNMENT**

Date of Injury: \_\_\_\_\_ Time of Injury: \_\_\_\_\_

Type of Accident or Injury:  Auto  Work Related \_\_\_\_\_ Other

Where did the accident occur? \_\_\_\_\_

Describe how it happened: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If an auto accident:

Were you  driver  passenger  pedestrian \_\_\_\_\_ other?

Did your care strike the other?  Yes  No

Did the other car strike yours?  Yes  No

Were you struck from:  behind  front  left  right?

Were traffic citations issued to:  you  driver of your car  driver of other car  none

Have you contacted an attorney?  Yes  No

Name \_\_\_\_\_ Phone: \_\_\_\_\_

If a work injury:

Did you report this to your employer?  Yes  No

Did they recommend care at our office?  Yes  No

Are you right  or left  handed?

Describe in detail, any symptoms immediately following the accident/injury.

\_\_\_\_\_  
\_\_\_\_\_

Have you had any of these symptoms before?  Yes  No If so, which ones? \_\_\_\_\_

\_\_\_\_\_

Describe any new symptoms since accident/injury:

\_\_\_\_\_  
\_\_\_\_\_

Have you had a previous injury to the presently injured area?

Yes  No If so, how did it happen? \_\_\_\_\_

Have you lost any time from work?  Yes  No

Dates: From \_\_\_\_\_ through \_\_\_\_\_.

Were you hospitalized?  Yes  No If so, where? \_\_\_\_\_

**Authorization to Use or Disclose Protected Health information**

**ACU-CARE TOTAL HEALTH**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Request: \_\_\_\_\_

As required by the Privacy Regulations, Acu-Care Total Health may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or associates of this office and :

- my attorney and/or insurance company

Patient Health Information authorized to be disclosed:

- for this injury only.

For the specific purpose of:

- treatment and payment.

Effective dates for this authorization: \_\_/\_\_/\_\_ through \_\_/\_\_/\_\_. This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reason beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

\_\_\_\_\_  
Signature of Patient or Patient's Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Signature of Facility

\_\_\_\_\_  
Date