ALLIED HEALTHCARE, PLLC

WORKER'S COMPENSATION INJURY

Patient Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____)_____ Cell Phone: (____)_____ Work: (_____)_____

Birthdate: _____ Sex: M _____ F ____ Social Security Number: _____

Email Address: _____ Primary Care Physician: _____

Work: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Who can we thank for referring you to our clinic? _____

Are you pregnant? Y ____ N _____ If so, (CONGRATS!!) please list your due date: _____

Date of accident: _____

Disability: Date last worked: _____ Date returned to work: _____

Employer: Name: _____

Address: _____

_____

Phone: (____)_____ Contact Person: _____

Workers Compensation Carrier: Name: _____

Address: _____

_____

Phone: (____) _____ Contact Person: _____

Do you wish billing to be forwarded to employer or insurance carrier: (Who is responsible for bill)

- □ Employer
- □ Insurance Carrier

The above patient has advised me of his/her work-related injury and that he/she is being treated by:

Provider Name: _____

Address: _____

_____

_____

Phone: _____

Contact Person: _____

Authorized Representative Signature: _____ Date: _____

Printed Name: _____

Please answer all questions.

Date injury Occurred: _____ What time: _____ AM/PM

Where did this injury occur? Address: _____

_____

Did you notify your employer of this accident? (Circle) YES NO

Have you retained an attorney? (Circle) YES NO

If yes, Name: _____

Address: _____

_____

Are you currently on litigation for this injury? (Circle) YES NO

Please explain how the injury or illness occurred:

_____
_____
_____
_____

What injuries did you suffer:

_____
_____
_____
_____

When was the last day you worked? _____

When did you return to work? _____

When was your first examination? _____

Who examined you? _____

Circle one if known: D.C. M.D. D.O. D.D.S.

What was the doctor's diagnosis? _____

Have you had treatments prior to coming o our office? (Circle) YES NO

If yes, please list what treatments you have received:

_____
_____

Have you previously injured this area before? (Circle) YES NO

If yes, when did this injury occur? _____

Did you lose time from this injury? (Circe) YES NO

If lost time from prior injury, please list doctor's who treated you:

_____

_____

Do you have any other injuries or illnesses that affect your employment? (Circle) YES NO

If yes, please explain:

_____

_____

In your work, do you favor one part of your body more than others? (Circle) YES NO

If so, please explain:

_____

_____

Do you have a history of absenteeism caused from accidents on the job? (Circle) YES NO

Have you ever filed a workers Compensation claim before? (Circle) YES NO

Before the injury, were you capable of working on an equal basis with others your age? (Circle) YESS NO

Are your work activities restricted as a result of this accident? (Circle) YES NO

Since this injury, are your symptoms: (Circle) IMPROVING GETTING WORSE SAME

HEALTH HISTORY:

EXERCISE		WORK HABITS		PERSONAL HABITS
___ None	___Moderate	___Sitting	___Standing	___Smoking
___ Daily	___ Heavy	___Light or	___Heavy Duty	___Alcohol
				___Coffee/Caffeine

List medications- including dosage and frequency if known. If there aren't any medications check here ____

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

List any known allergies you have had to any medications. If there are no allergies known, mark here ___

1. _____ 2. _____ 3. _____

List surgical operations and years:

_____

_____

Signature: _____ Date: _____

Parent/Guardian Signature: _____

Please be sure to fill this form out completely and accurately. Mark the area(s) of the body where you feel the described sensation(s). Use the appropriate symbol(s).

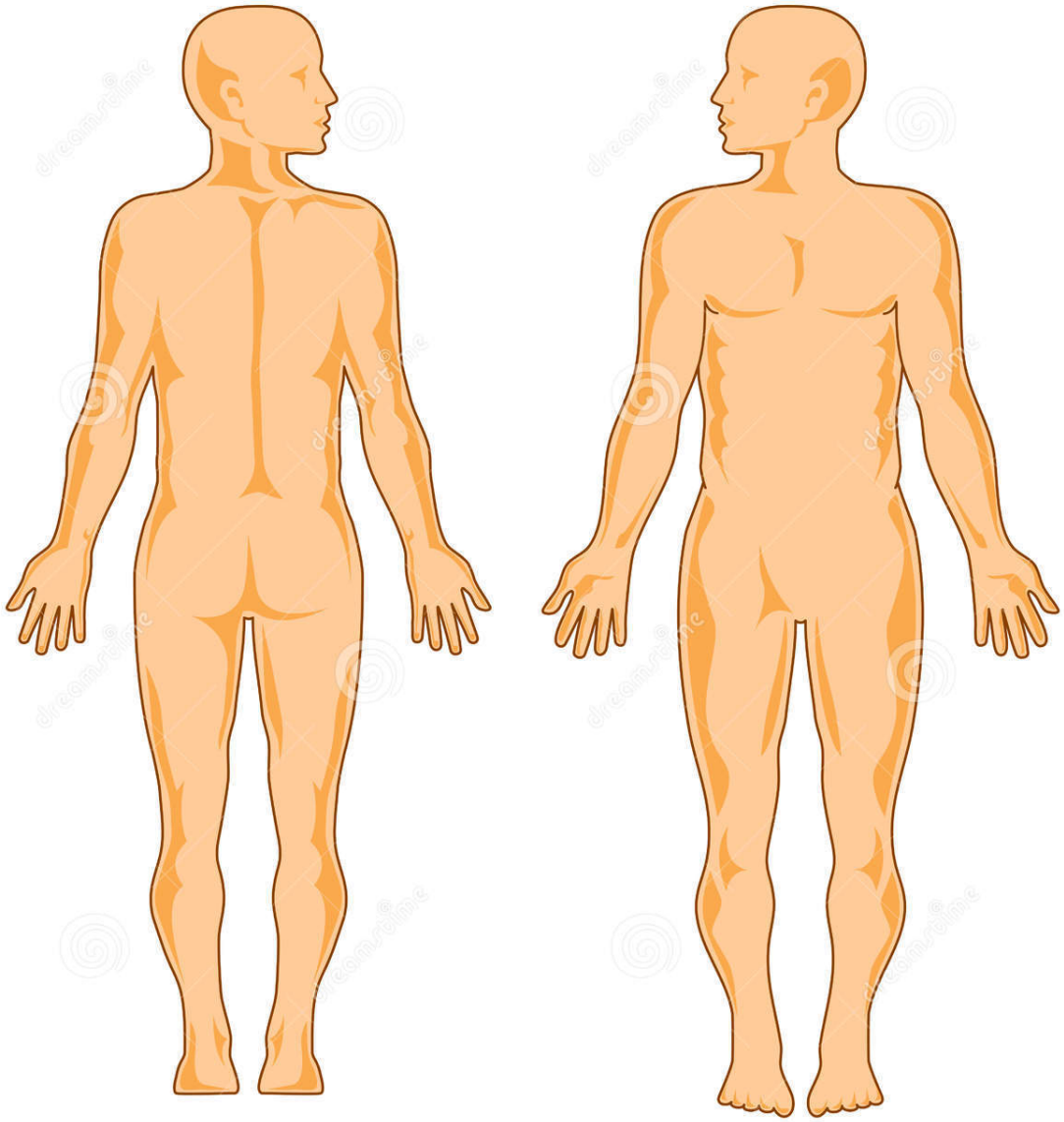
Aching Pain ******

Burning Pain XXXXXX

Numbness ======

Pins and Needles oooooo

Stabbing Pain //////



Record Release Authorization

Name: _____
Date of Birth: _____

I hereby authorize and request the release of my medical records

- ○ From
- ◉ To

Allied Healthcare, PLLC
3360 S 15th E
Idaho Falls, Idaho 83404
Phone 208-522-8300
Fax 208-524-6097

- ◉ From
- ○ To

Doctor/Clinic Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____-_____ Fax: (____) _____-_____

Thank you in advance for your cooperation and prompt reply.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature (For Minors) Date

_____ _____
Witness to above Signature Printed Name

Doctor's Lien

I do hereby authorize, Allied Healthcare/Dr. Aaron Nelson/Dr. Jeff Haskell/Dr. Stewart Curtis/Dr Scott Treat, to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself with regard to the accident which I was involved in on (date):_____.

I hereby authorize and direct you, my attorney, to pay directly to the said doctor(s) such sums as may be due and owing him for medical service(s) rendered me by reason of the above accident and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor(s). I hereby further give a lien on my case to said doctor(s) against any and all proceeds of me settlement, judgement or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or in connection herewith.

I agree to never rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney will honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him or her.

I fully understand that I am directly and fully responsible to the said doctor(s) for all medical bills submitted by him for service(s) rendered me and that this agreement is made solely for the said doctor(s) additional protection and in consideration of his waiting payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not wait for payment but declare the entire balance due and payable.

Patient Name_____ Date_____

Patient Signature_____ Date_____

Acknowledgement of Attorney

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms above and agrees to withhold such sums from the settlement, judgement or verdict as may be necessary to adequately protest said doctor(s) above named. Any settlement of this claim without honoring this assignment/lien will cause you to be responsible to this office for payment. The prevailing party in any litigation resulting from enforcement of this lien shall be entitled to actual attorney's fees and court costs.

Attorney Name_____ Date_____

Attorney Signature_____ Date_____

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgements based upon facts and information known to the doctor. The doctor uses this judgement based upon facts and information known to the doctor. The doctor uses this judgement to attempt to anticipate or explain the risks and complications and an undesirable result does not necessarily indicate an error in judgement. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course treatment based upon facts known that is in my best interest.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and sprain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that the best of my knowledge, I am not pregnant, nor is this pregnancy suspected or confirmed at this time. Date of last menstrual cycle:_____

Patient Name (printed): _____

Patient Signature:_____

Relationship or authority if not signed by Patient:_____

Witness:_____ Date:_____

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If you do not have insurance: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $300 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.**
2. **If you have insurance: All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance must not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.**

You are considered a cash patient until you bring in your complete insurance information, and we will qualify and accept your insurance coverage.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept the responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment. You further agree to pay as a collection fee of 33% of the principal amount to reimburse Allied Healthcare its collection costs if my account is assigned to a collection agency.

Personal Injury Cases: If an account balance is not paid in FULL within six (6) months of the first date of service, the patient will be required to begin making minimum monthly payments toward the account balance regardless of settlement/claim status.

If you discontinue care for any reason other than discharge by the doctoral balances will become immediately due and payable in full by you, regardless of any claim submitted.

We bill insurance carriers as a courtesy to our patients, it is not required by law for us to do so. It is ultimately the patients responsibility to contact your insurance carrier to determine what services may or may not be covered. It is also your responsibility to contact your insurance company regarding any questions of payment and/or denials of treatment.

Date:_____

Patients Printed Name:_____

Patient Signature or Legal Guardian:_____

ACKNOWLEGDEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received or asked for a copy of Allied Healthcare, PLLC's notice of Privacy Practices for protected health information.

Date:_____

Name of Patient (printed):_____

Signature of Patient/Personal Representative:_____