Worker's Compensation Accidental Injury

First Name_____ M.I._____ Last Name_____ Today's Date____/____/_____

Address_____ City_____ State_____ Zip Code_____

Home Phone Number (_____)_____-_____ Date of Birth_____/_____/_____Cell Phone (_____)_____-_____

Name of employer_____ Work Phone (_____)_____-_____

Address of employer_____Email_____

Date of accident_____/_____/_____ Time _____AM /PM Location_____

Date accident reported_____/_____/_____ To whom was it reported?_____

Have you lost any days of work as a result of this accident? ☐Yes ☐No Dates_____

Please describe how the accident happened:_____

_____

_____

_____

_____

Briefly describe your major complaint(s):_____

_____

Have you received medical care for your injuries? ☐Yes ☐No If so, where?_____

List the extent of the injuries as you know them:_____

_____

_____

Check symptoms you have noticed since the accident:

☐Neck pain	☐Problems with memory
☐Upper back pain	☐Diminished sense of smell/taste
☐Mid-back pain	☐Sensitivity to light
☐Lower back pain	☐Difficulty reading
☐Shoulder pain	☐Problems with balance
☐Chest pain	☐Nausea
☐Pain/Numbness in arms/hands	☐Poor appetite
☐Pain/Numbness in legs/feet	☐Trouble falling asleep
☐Headaches	☐Waking up during the night

Symptoms other than above:_____

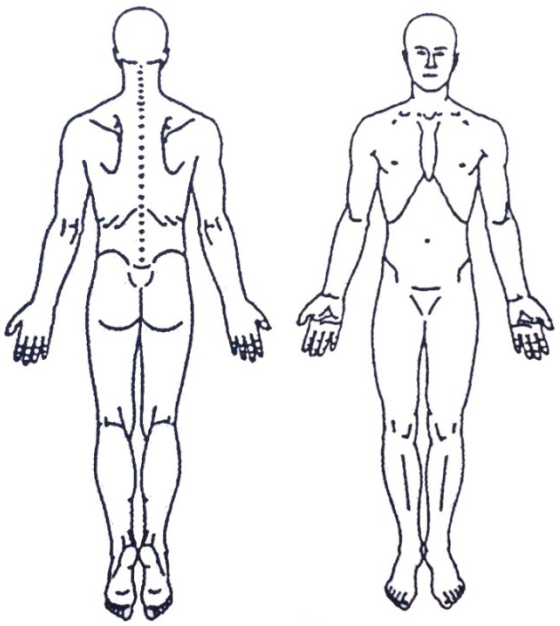
_____

_____

Where are you hurting the worst? _____

Is your condition getting: ☐worse ☐better ☐staying the same

Please mark the exact location(s) of your pain on the diagram below:



Bruising? Where?_____

Clark Chiropractic Center's Policy for Workers' Compensation Cases

I understand that in order for this office to accept assignment (file your insurance claims for you and wait for payment) I must first provide them with the following information. Otherwise, payment for todays visit is due at the time of service.

❑ Claim Number _____

❑ Accident Date _____

❑ Name of Supervisor _____

❑ Employer's Address _____ City _____ State ___ Zip _____

❑ Employer's Telephone Number _____

❑ Workers' Compensation Benefits Coordinator: _____

❑ Benefits Coordinator's Telephone number _____

❑ Name of Insurance Company _____

❑ Address of Insurance Company _____ City _____ State __ Zip _____

❑ Name of Representative _____

❑ Telephone number _____

❑ A copy of accident report

Name of my "regular" health insurance company _____

Whose name is the policy under? _____

Social Security Number of insured _____

Policy # _____ Group #: _____

Address of Insurance Company _____

City _____ State _____ Zip _____

Phone # _____

Until this information is verified by Clark Chiropractic Center, I further understand that any subsequent visits will also be my financial responsibility and will be due and payable at the time of the office visit.

Signature _____ Date _____

Dr. Steven E. Clark, Chiropractor • 418 East Diamond Avenue, Gaithersburg, MD 20877
(301) 926-1500 • fax: (301) 926-0462

CLARK CHIROPRACTIC CENTER

CLARK CHIROPRACTIC CENTER
PRACTICE'S REQUIREMENTS

The Practice:

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

(b) Under the Privacy Rule, may be required by State Law to grant greater access or maintain greater restriction on the use or release of your PHI than that which is provided by under Federal law.

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

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that is 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 APRIL 15, 2003

This notice is in effect as of 04-15-03.

PATIENT ACKNOWLEDGEMENT

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

PATIENT SIGNATURE: _____

PATIENT NAME: _____

DATE: _____

Assignment of Insurance Benefits

Clark Chiropractic Center
Dr. Steven E. Clark, Chiropractor
418 East Diamond Ave. Gaithersburg MD 20877
(301) 926-1500 * Fax:(301) 926-0462

I authorize permission to my insurance company that all bills submitted by Clark Chiropractic Center be paid directly to them. I understand that health and accident insurance policies are an arrangement between my insurance company and my self – not between my insurance company and this office. I further understand that filing insurance by this office is a courtesy provided to me.

I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports and forms collecting from my insurance company.

Name:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Relationship to the Insured:_____

Whose name is the policy Under?_____

Policy#_____ Group:_____

Insured's Date of Birth:_____

Social Security Number of Insured:_____

Insurance Company Name:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Insured's Employer_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Signature:_____ Date:_____

OFFICE POLICY AND CONSENT TO TREATMENT

APPOINTMENTS

On your first visit the doctor will take a thorough history, and perform a thorough examination, possibly including x-rays. On your second visit the doctor will recommend a treatment plan, laying out the number and frequency of appointments necessary to resolve your problem. You will get the best results, and save time and money, by following this schedule as much as possible. **Please schedule your appointments as far in advance as possible; and should you need to miss an appointment, please do your best to make it up within 7 days.**

PATIENTS WITH INSURANCE

As a courtesy, we will call to verify your insurance coverage, and explain it to you. **Please understand that we are sometimes given incorrect information, and insurance companies have no legal obligation to honor what they tell us.** It is always a good idea to call yourself to double check on your coverage, and to ask for the name of the agent that you speak with. After this is done, and any deductible has been met, we will collect your co-pay at the time of service and wait up to 60 days for your insurance to reimburse the rest.

We file claims monthly. **Should your insurance company deny payment or take over 60 days to pay, you will need to pay any outstanding balance at that time, and resolve the problem with your insurance company. We will provide you with any records you may need to accomplish this, but we cannot fight the insurance company for you.** Your insurance policy is a contract between you and your insurance company. Filing insurance claims is a courtesy provided to you without charge, and in no way relieves you of the responsibility for your bill.

We do not file for secondary insurance, but we will be happy to print out your claims so that you may do so.

ZERO BALANCE POLICY

Our office policy is that all accounts must be current before any further services can be rendered.
After 60 days, any amount due will automatically enter the collection process. Any fees incurred in collecting the overdue amount will be automatically added to the bill.

CONSENT TO TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays on me by the doctor or authorized staff member. I have had the opportunity to discuss with the doctor or staff member the nature and purpose of these procedures, and any concerns I may have. I understand that results are not guaranteed.

I further understand that although chiropractic treatment is extremely safe, no medical or physical treatment is without risk. I do not expect the doctor to be able to anticipate and explain all possible risks, and wish to rely on his judgment as to the safety and appropriateness of any treatment provided to me.

I have read and understand the above, and I consent to all examinations and care as deemed appropriate by the doctor for my present condition, and for any future conditions for which I may seek care. I realize that I may ask any questions to the doctor either before or after I sign this contract, and I understand that my consent can be withdrawn at any time.

(Signature)_____ (Date)_____