Injury Rehab Associates

Telephone: (702)509-5098 Fax: (702)924-6356 Email: info@injuryrehab.org

PATIENT INFORMATION

Name_____ Date_____

Date of Birth_____ Social Security #_____

Street Address_____

City_____State_____Zip_____

Home Phone_____Cell Phone_____Email_____

Occupation_____Unemployed YES NO

Employer_____Supervisor_____

Employer Address_____

Employer Phone_____Length of Employment_____

Sex: ☐ Male ☐ Female Height_____Weight_____Dominant Hand ☐ Left ☐ Right

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other_____

Are you: ☐ Married ☐ Single ☐ Domestic Partnership ☐ Divorced ☐ Separated ☐ Widowed

Spouse Name_____# of Children_____

Emergency Contact Name_____Cell Phone_____

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Primary Health Insurance_____Waiver Signed ☐

Policy ID_____Group Number_____

Subscribers Name_____Subscribers DOB_____

Secondary Insurance Carrier_____

Policy ID_____Group Number_____

Subscribers Name_____Subscribers DOB_____

PATIENTS AUTOMOBILE INSURANCE INFORMATION

Drivers Name_____Policy Holders Name_____

Policy Holders Car Insurance Carrier_____Phone #_____

Adjusters Name_____Claim #_____

OTHER AUTOMOBILE INSURANCE INFORMATION

Has the accident been reported to the other driver's insurance company? ☐ Yes ☐ No

Drivers Name_____Policy Holders Name_____

Policy Holders Car Insurance Carrier_____Phone #_____

Adjusters Name_____Claim #_____

WORKERS COMPENSATION

Date of Injury_____W/C Carrier_____Claim #_____

Who is/was your employer at the time of injury?_____

Employer Address_____

Employer Phone #_____Supervisors Name_____

Have you filed a "First Report of Injury" with your employer? ☐ Yes ☐ No

ACCIDENT INFORMATION

How were you injured? ☐ Auto ☐ W/C ☐ Slip & Fall ☐ Other:_____

Date of Injury_____ What State?_____

Attorney Name_____Attorney Phone_____

Did the police appear at the scene of the accident?_____If no, why?_____

Brief description of how the accident happened_____

_____

Were you the: ☐ Driver ☐ Passenger ☐ Back Seat Seat Belt On? ☐ Yes ☐ No

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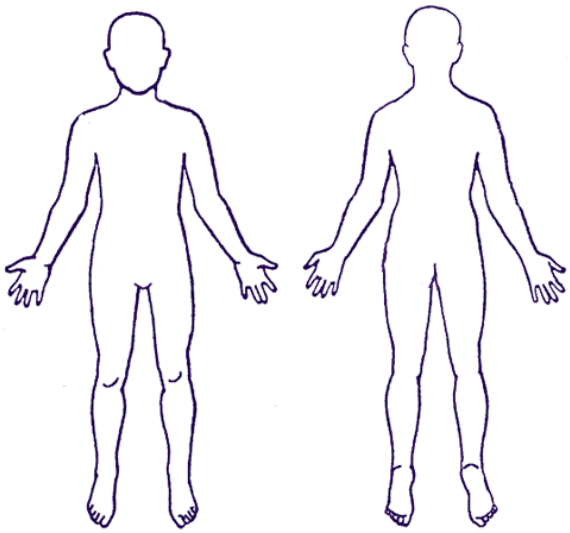
How did your problems begin? _____

_____

Rate your pain: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Draw your pain:



Describe you pain: ☐ Dull ☐ Ache
☐ Sharp ☐ Stabbing ☐ Pins & Needles
☐ Shooting Pain ☐ Burning ☐ Throbbing
☐ Twinge ☐ Numbness/Tingling
☐ Other _____
Is your pain constant? ☐ Yes ☐ No
Intermittent? ☐ Yes ☐ No
Fluctuates with activity? ☐ Yes ☐ No
Wakes you up at night? ☐ Yes ☐ No

What makes the symptoms worse?
☐ Sitting ☐ Standing ☐ Walking
☐ Lifting ☐ Bending ☐ Lying Down
☐ Squatting ☐ Stress ☐ Other _____
Are you ever totally pain free? ☐ Yes ☐ No

What makes your symptoms better? ☐ Sitting ☐ Standing ☐ Walking ☐ Lifting
☐ Bending ☐ Lying Down ☐ Other _____

What time of day are your symptoms the worst? _____ Best?_____

Do you feel you are: ☐ Getting better ☐ Getting worse ☐ Staying the same

Have you had this problem before? ☐ Yes ☐ No
If yes, when and how did it get better? _____

_____

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HISTORY OF ACCIDENTS/SURGERIES

WHEN	WHERE	INJURIES	TREATED BY	DATE OF LAST TREATMENT	FULL RECOVERY?

Have you been able to work since your accident? ☐ Yes ☐ No

Last day worked?_____

Has an out of work slip been issued to you? ☐ Yes ☐ No

Any previous treatment for your current condition? ☐ Yes ☐ No

Have you had diagnostic studies for your current condition? (x-ray, MRI, CT scan…)

☐ Yes ☐ No

Any orthopedic problems? ☐ Yes ☐ No

If yes, please explain: _____

_____

Any medical problems? ☐ Yes ☐ No

If yes, please explain:_____

_____

Please list **ALL** medications you are currently taking such as prescription and over-the-counter for this and any other condition:_____

_____

_____

Does your current condition limit you in carrying out job duties? ☐ Yes ☐ No

Household duties? ☐ Yes ☐ No

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Motor Vehicle Collision/Personal Injury Questionnaire

1) Make and model of your vehicle:_____

2) Make and model of other vehicle:_____

3) What direction was your vehicle going?_____

4) What direction was the other vehicle going?_____

5) Was the impact from the: ☐ Front ☐ Rear ☐ Left Side ☐ Right Side

6) Was your vehicle in: ☐ Park ☐ Neutral ☐ Moving ☐ Stopped

7) Were your brakes being applied? ☐ Yes ☐ No

8) Approximate speed of impact: Your vehicle:_____mph Other Vehicle:_____mph

9) Was your vehicle shoved: ☐ Forward ☐ Backward ☐ Sideways

10) Did your vehicle go into a spin or roll because of the impact? ☐ Yes ☐ No

11) What was the weather at the time of the collision: ☐ Dry ☐ Wet ☐ Icy

12) Were you (your body) shoved: ☐ Forward ☐ Whipped Back ☐ Sideways

13) Were you holding onto the steering wheel? ☐ Yes ☐ No

14) Were you: ☐ Braced for the impact ☐ Surprised by the impact

15) Did you brace your arms against the dashboard? ☐ Yes ☐ No

16) Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was its position? ☐ Low ☐ Mid-position ☐ High

Did your head hit the headrest? ☐ Yes ☐ No

17) Did any part of your body hit the interior of the vehicle? ☐ Yes ☐ No

☐ Seatbelt ☐ Steering Wheel ☐ Dashboard ☐ Windshield ☐ Side Door

☐ Side Window ☐ Other:_____

Which part of your body: ☐ Chest ☐ Head ☐ Chin ☐ Face ☐ R L Knee

☐ R L Shoulder ☐ R L Hand ☐ Other:_____

18) How much damage was there to the outside of the vehicle?

☐ Totaled ☐ Heavy ☐ Moderate ☐ None

19) How much damage was there to the inside of the vehicle?

☐ Totaled ☐ Heavy ☐ Moderate ☐ None

20) At the point of impact, where did you experience pain? Please be specific:_____

_____

21) Immediately after the accident, were you: ☐ Conscious ☐ Dazed ☐ Unconscious

If you lost consciousness, for how long?_____

22) At the time of impact, were you looking:

☐ Straight Ahead ☐ To the Right ☐ To the Left ☐ Down ☐ Up

23) Did your seat break because of the impact? ☐ Yes ☐ No

24) Did you go to the hospital? ☐ Yes ☐ No

When? ☐ Right After the Accident ☐ Next Day ☐ Other:_____

How did you get there?_____

If by ambulance, were you placed in a: ☐ Neck Brace ☐ Back Brace

☐ Other:_____

25) If you went to the hospital, please answer the following:

Name of Hospital:_____

Diagnosis/Treatment:_____

Any medications or medical supplies given:_____

_____

26) Have you done any at home treatment? If so, please explain:_____

_____

Print Name_____

Patient Signature_____Date_____

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Waiver of Insurance Billing

Patient Name:_____

DOB:_____Date of Injury:_____

You have registered as a **lien/third party patient.** This means that at the time of service you will be treated on a lien.

We will not bill your health insurance for services provided under this arrangement. No forms will be produced now or in the future for you or us to submit for insurance billing.

Please contact our lien department if you have any questions regarding this arrangement.

I agree to:

1)pay at the time of my personal injury settlement, and

2)waive insurance billing

Patient Signature_____

Date_____

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AUTHORIZATION TO RELEASE/RECEIVE MEDICAL AND/OR OTHER INFORMATION

I hereby authorize Injury Rehab Associates to release and/or to receive any and all records/documentation including, but not limited to, alcohol/drug abuse, psychiatric, radiology films/reports, medical history, and coverage information pertaining to applicable health insurance(s).

Patient Name_____

Patient SSN_____

Patient DOB_____

Patient Signature_____Date_____

(*If the Patient is a Minor): Signature of the Parent of Legal Guardian

_____

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IRREVOCABLE ASSIGNMENT OF PROCEEDS

Date_____ Date of Injury_____

Patient Name_____ DOB_____

I, the undersigned Patient (or legal guardian of a minor), (also referred to below as "Patient") of Injury Rehab Associates ("Rehab Facility"), forever and irrevocably assign any and all proceeds that I receive from the Insurance Company(ies) above-stated, to be paid directly to Rehab Facility for services rendered to me in connection with the Date of Injury indicated below.

I authorize and direct Insurance Company(ies) to withhold from any settlement, judgement or verdict the full amount of the unpaid medical services rendered to me by Rehab Facility.

I authorize and direct Rehab Facility to furnish the Insurance Company(ies) with all reports, findings, interpretations, impressions, treatments, diagnoses, or diagnostic studies that Rehab Facility may perform on me in connection with any injury in which the I was involved on or about the Date of Injury.

I fully understand that I am directly and fully responsible to Rehab Facility for all medical bills associated with the services rendered to me, whether or not there is any financial recovery from the Insurance Company(ies) or other sources.

If Patient does not have an attorney and later decides to retain one then I agree to promptly (1) furnish Rehab Facility with contact information concerning that attorney and (2) notify that attorney concerning existence of this Irrevocable Assignment of Proceeds.

In the event that Patient is paid by the way of settlement, judgement or verdict, I agree not to accept any money from either the Insurance Company(ies) or attorney from any of the proceeds that I have assigned to and is intended for this Rehab Facility. Rehab Facility shall be paid in full out of the first proceeds received paid by Insurance Company(ies) or attorney.

Print Name of Patient_____

Signature of Patient_____

INSURANCE COMPANY: IF COMPANY POLICY REQUIRES A RECORDED/FILED LIEN FOR DIRECT PAYMENT, PLEASE CONTACT OUR OFFICE PRIOR TO SETTLING CASE. OUR SERVICE WILL PROVIDE YOU WITH ONE.

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LIEN

NAME OF PATIENT_____DOB_____DOL_____

ATTORNEY NAME_____TEL_____FAX_____

I assign to Injury Rehab Associates any and all settlement proceeds, judgements, and/or verdicts related to the above-stated injuries to the extent necessary to pay my account balance in full. I authorize and direct my attorney and/or insurance carrier(s), to (1) withhold from any settlement proceeds, judgements, and/or verdicts monies sufficient to satisfy my account balance with Injury Rehab Associates upon receipt of same.

Under special circumstances, I hereby authorize Injury Rehab Associates to bill their full charges for medical care rendered to me with automobile insurance carriers for medical payment coverage, if applicable. I hereby acknowledge that Injury Rehab Associates has not stated, recommended, counseled, advised or otherwise suggested that the patient should not utilize any health insurance for services. If I am insured by a health insurance carrier and signed a Waiver of Insurance, I did so at my own discretion.

I agree never to rescind this document and that rescission will not be honored by my attorney. I hereby instruct, in the event another attorney is substituted in this matter, that the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her. I understand that if I change attorneys for any reason, I will notify Injury Rehab Associates within 72 hours or I will be solely responsible for payment-in-full immediately.

I have been advised that if my attorney does not wish to cooperate in protecting Injury Rehab Associate's interest, the clinic will not await payment but will require me to pay for rehabilitation services as they are rendered. Whether or not I retain an attorney to represent me, I understand that Injury Rehab Associates in its sole discretion, may hire an attorney or outside company to its legal and/or lien interests, and I agree to cooperate with Injury Rehab Associates designated representative and provide them with the information requested, to discuss legal matters and options, and/or to secure medical payments relating to my case.

I further acknowledge and agree that any account balance with Injury Rehab Associates that remains outstanding 30 days after the settlement/resolution of the case shall incur a compounding interest rate of 1.5% per month. I also acknowledge and agree that, in the event I do not pay for rehabilitation services rendered by Injury Rehab Associates the clinic must place my account with an attorney and/or a collection agency, I will pay reasonable attorney fees, and court costs incurred in collecting my overdue account.

PATIENT NAME_____DATE_____

PATIENT SIGNATURE _____

The undersigned, being the attorney of record for the above patient, hereby agrees to observe all the terms of this Financial Agreement.

ATTORNEY NAME_____SIGNATURE_____DATE_____

Please fax lien back to (702)924-6356 * If you have any questions, please call (702)509-5098

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Consent for Purposes of Treatment, Payment and Healthcare Options

I consent of the use of disclosure of my protected health information by Injury Rehab Associates for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations of Injury Rehab Associates. I understand that diagnosis or treatment of me by Injury Rehab Associates may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health operations of the practice. Injury Rehab Associates is not required to agree to the restrictions that I may request. However, if Injury Rehab Associates agrees to a restriction that I request, the restriction is binding on Injury Rehab Associates. I have the right to revoke this consent, in writing, at any time, except to the extent that Injury Rehab Associates has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or conditioned and identifies me, or there is a reasonable basis to believe the information may identify me.

_____ _____

Signature of Patient or Personal Representative Printed Name of Patient

Date: _____

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Acknowledgement of Missed Appointments

I acknowledge that I am responsible to make all my scheduled appointments on time. If I fail to do so resulting in a no call or no show, I am responsible to pay a fee of $50.00. I acknowledge I must call 24 hours in advance to avoid paying this fee. This fee will be put on my attorney lien and paid at the end of my settlement. This fee will also be applied if I am later than ten minutes to my appointment. It will not be taken out of Injury Rehab Associates bill; it will be taken out of my settlement.

Patient Name:_____ Date: _____

Patient Signature: _____