REV. 12.16.2019

ALLEGHENY MEDICAL
COMPLETE CARE. ONE PLACE.
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DAY	Date	Time
DOC:		Acct#
Conf: Yes No		Staff:

WORKERS COMPENSATION INTAKE FORM

Full Legal Name: _____ /_____ /_____
Last Name *First Name* *Middle Initial*

Age: _____ Date of Birth: _____ /_____ /_____ S.S. #: _____-_____-_____

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

(H) Phone # (____)_____ Mobile # (____)_____ (select one) Best # to reach you ☐ H or ☐ M

E-mail address: _____ Gender: Female ☐ (Pregnant? ☐) Male ☐

Single ☐ Married ☐ Other ☐ Spouse or Partner Name: _____

Employer / School: _____ Phone# (_____)_____

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

Occupation: _____ circle which applies: ☐ Full time ☐ Part time ☐ Student ☐ Retired

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Phone#(_____)_____

Other than yourself, to whom may we disclose your Protected Health Information?_____

PCP AND CURRENT PHARMACY INFORMATION: (if no PCP, please put N/A in "Family MD" area)

Family MD _____ Phone # _____

Pharmacy _____ Phone # _____

How did you hear about us? (Please select all that applies) ☐ TV ☐ Billboard ☐ Radio ☐ Internet ☐ OTHER_____

If referred by our patient, please print their name(s):_____

Is there any place you do NOT want us to leave a message? _____

HEALTH INSURANCE INFORMATION:

PLEASE PROVIDE YOUR INSURANCE CARD(S) TO FRONT DESK FOR SCANNING/COPYING

We keep this info, in case your worker's comp is denied, then your health insurance will be billed.

Do you have medical insurance? Yes ☐ No ☐
Do you have Medicare? Yes ☐ No ☐
Insurance Company Name _____
Insurance Company Phone_____
Type of Insurance: ☐ HMO ☐ PPO ☐ POS ☐ OTHER
Policy#_____ Group#_____
Policy Holders Name _____
Their DOB:_____ Relationship _____

Do have any other insurance? Yes ☐ No ☐
If Yes, complete below;
Insurance Company Name _____
Insurance Company Phone_____
Type of Insurance ☐ HMO ☐ PPO ☐ POS ☐ OTHER
Policy#_____ Group#_____
Policy Holders Name _____
Their DOB:_____ Relationship _____

Do you have any known contagious diseases at this time? ☐ **Yes**, (Explain)_____ or ☐ **No**

WORKER'S COMPENSATION INFORMATION:

Was your injury work related? ☐YES ☐NO

Was it reported to your employer? ☐YES ☐NO

To Whom? _____ Telephone # _____ Ext._____

Date of Injury: _____ Where did injury occur? _____

Explain in your own words how injury occurred:_____

_____

Are you currently off work? ■YES □ NO If yes, last day worked? _____ / _____ / _____

Who took you off work _____ When? _____ / _____ / _____

Who did you report this accident to? _____

Did you go to the hospital? □YES □NO If yes, where & when _____

How long were you hospitalized for? _____

Are you on any medications because of this accident? □YES □NO

If YES Describe_____

How would you describe the pain you felt immediately following your injury?

□ grabbing feeling □ sharp pain in one spot □ sharp pain with radiating symptoms
□ popping feeling □ dull ache □ other _____

Please describe your current symptoms _____

_____

Have you been treated by anyone for the injury or symptoms? □YES □NO

If yes explain:_____

PATIENT NAME:

PLEASE SELECT THE FOLLOWING ANSWERS RELATING TO YOUR WORK INJURY:

My injury occurred:

While I was carrying an object & lost my balance:	☐ YES	☐ NO
While a falling object struck me:	☐ YES	☐ NO
While I was driving on the job:	☐ YES	☐ NO
While I was doing the same task over & over	☐ YES	☐ NO
When I lifted something	☐ YES	☐ NO

I suffered the injury while lifting □ from the floor □ from a surface over my head
□ from surface about waist height □ other _____

The object I lifted was?
□2-5 lbs □5-10 lbs □10-15 lbs □ 15-20 lbs □ 20-25 lbs □25-50 lbs □50 + lbs

When I was lifting, I □ had my back straight □ was bent at the waist
□ was twisted to the side □ other_____

I fell at work, □ onto the surface I was walking on
□ from the surface 2-4'high
□ from a surface 4-6 'high
□ from a surface 6-8' high
□ from a surface 8 +' high
□ other_____

When I fell the □ surface was wet □ surface was icy
□ surface had liquid on it □ tripped over object
□ rug/carpet was uneven □ Other_____

When I fell,
I landed on my □ back □ knees □ left side
□ stomach □ rear end □ right side □ outstretched arm

I hit the left side
of my □ back □ head □ elbow □ tailbone □ foot □ knee
□ arm □ hand □ wrist □ shoulder □ ankle □ hip □leg

I hit the right side
of my □ back □ head □ elbow □ tailbone □ foot □ knee
□ arm □ hand □ wrist □ shoulder □ ankle □ hip □leg

My injury occurred when I
□ carried an object □slipped & fell □coughed □sneezed □twisted at waist
□ straightened up from bending position □ straightened up from a sitting position
□ other_____

If injury occurred differently than anything mentioned above, please describe: _____

_____

WORKER'S COMPENSATION INSURANCE INFORMATION:

Carrier Name: _____

Address: _____

Telephone #_____

Claim #_____

ATTORNEY INFORMATION:

Have you obtained an attorney? □YES □ NO

If yes, Name: _____

Address: _____

Telephone # _____

NON WORK RELATED:

During future visits at Allegheny Medical Integrated Medicine, you have available, a team of providers to assist you with your health care. Please mark those providers that you would be interested in seeing to help you reach all your health care needs.

□Primary Care □ Family Care □ Physical Therapy □ Chiropractic □ ALLERGY

Please describe your current NONWORK RELATED symptom(s) _____

Approximant date began _____.

Medications and Supplements: What medications (prescribed or over the counter) are you currently taking? Including Vitamins?

_____

_____

MEDICATIONS AND SUPPLEMENTS:
What medications (prescribed or over the counter) are you currently taking? Including Vitamins?

_____ _____
_____ _____
_____ _____
_____ _____

PATIENT NAME:

PAST HISTORY INFORMATION:

Please check any of the following, that applies to you, currently or in the past;

MEDICAL HISTORY:

General

Headaches	☐	Chills	☐	Hoarseness	☐
Neck pain/ stiffness	☐	Depression	☐	Hay Fever	☐
Shoulder pain/ stiffness	□(R) □(L)	Dizziness	☐	Nose Bleed	☐
Arm/Hand pain/ stiffness	□(R) □(L)	Fainting	☐	Sinus problems	☐
Hip pain/stiffness	□(R) □(L)	Fever	☐	Vision problems	☐
Leg/Foot pain/ stiffness	□(R) □(L)	Forgetfulness	☐	**GASTROINTESTINAL**	
Upper Back pain/ stiffness	☐	Headaches	☐	Constipation	☐
Lower Back pain/ stiffness	☐	Loss of sleep	☐	Diarrhea	☐
High Blood Pressure	☐	Nervousness	☐	Excessive hunger	☐
Diabetes	☐	Numbness	☐	Excessive thirst	☐
TMJ (Jaw Problems)	☐	Sweats	☐	Gas	☐
Stomach/Intestinal Problems	☐	**EYES, EARS, NOSE**		Hemorrhoids	☐
Lung problems	☐	Ear discharge	☐	Other info not listed	☐
Communicable Diseases	☐	Earache	☐		
Bloating	☐	Loss of hearing	☐		
Menstrual Problems	☐	Ringing in Ears	☐		
Pregnancy	☐	Bleeding gums	☐		
Prostate Problems	☐	Difficulty swallowing	☐		
Chronic Pain Syndrome	☐	Blurred vision	☐		
Memory Loss	☐	Double vision	☐		
Bowel/Bladder Problems	☐	Crossed eyes	☐		
		Persistent Cough	☐		

Tobacco ☐ YES ☐ NO How often?_____
Alcohol ☐ YES ☐ NO How often?_____
Caffeinated Beverages ☐ YES ☐ NO How often?_____
Recreational Drugs ☐ YES ☐ NO IF YES, Please discuss w/ doctor.

Have you had any surgeries? If so, please list: _____
_____

Food, drug, or latex allergies? If so, please list: _____
_____

PATIENT NAME:

RATE YOUR CHIEF COMPLAINT IN ORDER OF SEVERITY FROM WORST (10) TO LEAST (1):

Please check all that apply:

Pain ☐ Decreased Motion ☐ Swelling/Edema ☐ Stiffness ☐ Loss of Function ☐

INDICATE THE NATURE OF YOUR PAIN/SYMPTOMS. CHECK ALL THAT APPLY:

Sharp ☐ Dull ☐ Piercing ☐ Shooting ☐ Aching ☐ Deep ☐ Superficial ☐

Tingling ☐ Numbness ☐ Burning ☐ Stabbing ☐

What makes your symptoms worse?_____

What makes your symptoms/pain lessen?_____

Rate your symptom/pain on scale (0-10): no pain=0, excruciating pain =10

Worst it has been_____ Past 2 weeks_____ Past 24hrs_____ At this moment____

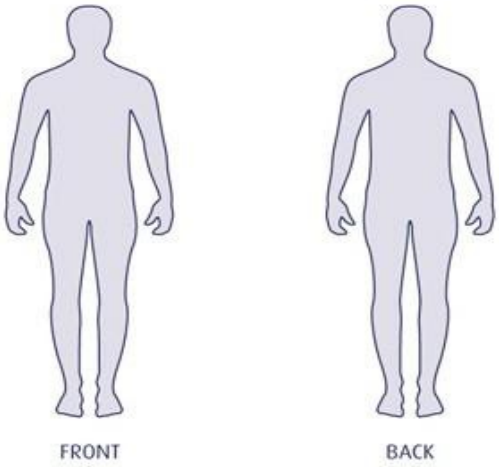
PLEASE MARK LOCATION OF YOUR PAIN AND TYPE OF PAIN ON THE CHART:

X: Sharp stabbing

O: Dull/achy

///: Numb/Tingling

++: Burning



Please list 3 of your goals for recovery and expected time frame:

1._____

2._____

3._____

The patient or legal guardian must sign authorizations, such as in the case of a minor or when the patient is physically or mentally incompetent to sign. If patient is able to sign by marking an X, legal guardian must witness signature.

CONSENT FOR TREATMENT:

The signature below authorizes consent to have your picture taken for the sole purpose of identification. This material will not be sold or distributed for any reason.
The information I have provided is complete and true to the best of my knowledge. I authorize the doctors and staff of Allegheny Medical, P.C. to administer such procedures and treatment as deemed necessary, or as required by my employer. There is no written, verbal, or implied guaranteed cure on our part. Due to our commitment to quality healthcare, we strive to improve services to our patients and we ask your consent prior to rendering treatment or services.

Signature of Patient _____ Date: _____

Signature of Guardian_____ Date: _____

ASSIGNMENT OF BENEFITS:

I _____ authorize Allegheny Medical, P.C. to be paid directly for services rendered. I accept responsibility for any service(s) that may not be covered by my health insurance, automobile insurance, or workers compensation carrier. I further authorize Allegheny Medical, P.C. to furnish information concerning my present illness or injury which may contact alcohol, drug, HIV or psychiatric related history to the insurer and health care providers involved in my care. I further direct the insurer to pay without equivocation directly to Allegheny Medical, P.C. any and all benefits due as a result of treatment and service(s) provided. I am aware that I am personally responsible for charges and/or balances not covered by my insurance carrier.
I hereby state and agree that a photocopy of this document will be deemed as valid and bindings on all parties involved as the original copy.

Signature of Patient _____ Date: _____

Signature of Guardian_____ Date: _____

MEDICARE ASSIGNMENT OF BENEFITS:

In accordance with the Medicare Act, Section 1842 (I) this letter is to advise you that Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862 (a) (II) (A) of the Medicare act. If Medicare determines that a particular service(s), although normally covered is not reasonable and necessary because the service(s) is maintenance in nature as defined by Medicare policy, Medicare will deny payment for those service(s). In your case, Medicare is likely to deny payment for the service(s) for lack of medical necessity. By my signature, I acknowledge notification by Allegheny Medical, P.C. that in my case, Medicare is likely to deny payment for those service(s).

If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signature of Patient _____ Date:_____

Signature of Guardian_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY:

PRACTICES FOR PROTECTED HEALTH INFORMATION

□ I acknowledge that I have received and read "Notice of Privacy Practices" from Allegheny Medical, P.C.

_____	_____	_____
DATE	PRINT NAME OF PATIENT	SIGNATURE OF PATIENT/PERSONAL RESPRESENTATIVE

□ I decline to read or accept a copy of the "Notice of Privacy Practices" from Allegheny Medical, P.C.

_____	_____	_____
DATE	PRINT NAME OF PATIENT	SIGNATURE OF PATIENT/PERSONAL RESPRESENTATIVE

ALLEGHENY MEDICAL
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Narcotic Prescription Policy

- **Each prescription will be written for a 30-day supply.**
- **Patient will need to be seen every 90 days; preferably, but not necessarily, by the provider initially prescribing the medication or more frequently as determined by the provider.**
- **Narcotic prescriptions need to be picked up at the office. The patient must do so themselves unless other arrangements are made previously and approved by the practice. A photo ID must be presented by anyone picking up the prescription. If someone other than the patient is picking up the prescription, the person picking up the prescription must be listen on the patient's HIPAA release of information form and in the patient's electronic medical record.**
- **Patient needs to use the same pharmacy all the time.**
- **If we find that the patient is obtaining narcotics from another provider, we will terminate our relationship immediately unless the medication is related to a post-surgical procedure.**
- **Patients are responsible for the controlled substance prescription given to them. If prescriptions are misplaced, stolen, lost or if the medication "runs out early," the medication will not be replaced under any circumstance.**
- **Patients will be subject to random urine drug screening to verify that medications are being taken as prescribed. This will be at the provider's request. Urine drug screens cannot be billed to insurance and will be charged to the patient. Failure to comply will result in discontinuation of the medication and possible discharge from care.**

Thank you for your cooperation in this matter.

I have read and understand my responsibilities as outlined above. I acknowledge the receipt of the notice of the narcotic policy.

Patient Signature: _____ DOB: _____

Print Name: _____ Date: _____