BURGER
PHYSICAL THERAPY

Date: _____

GENERAL INFORMATION:

Patient name: _____ ☐ male ☐ female

Date of birth: ____/____/____ Age: _____ Number of siblings: _____ Sibling ages: _____

Parent's name: _____ Parent's name: _____

Home phone: (____) _____ Other phone: (____) _____

Child attends: ☐ Daycare ☐ Preschool ☐ Grade school (grade ____) # Days per week attended: _____

Language(s) spoken at home: _____

CONCERNS: What brings you to Burger Pediatric Center?

MEDICAL AND DEVELOPMENTAL HISTORY:

1. Complications during pregnancy (illness, infections, stress, etc.)? ☐ No ☐ Yes (describe below)

2. Complications during labor/delivery (forceps, vacuum, C-section, induced delivery (etc.)? ☐ No ☐ Yes (describe below)

3. Birth weight: _____lbs. _____oz. ☐ Premature ☐ Post-mature ☐ Full term
   APGAR score at 1 minute: _____5 minutes: _____

DEVELOPMENTAL MILESTONES:

4. At what age did your child:
   Roll: _____ Sit: _____ Crawl: _____ Cruise: _____ Stand: _____ Walk: _____
   Use early words: _____ Speak in sentences: _____

(Please continue on next page.)

Patient name:

MEDICAL HISTORY:

5. Does your child have a medical diagnosis? ☐ No ☐ Yes (detail below)
   Diagnosis: _____
   Age at diagnosis: _____ Diagnosed by: _____

6. Does your child have issues with any of the following? (Check all that apply.)
   ☐ Restricted diet ☐ Swallowing problems ☐ Chewing/gagging problems ☐ Picky eater

7. Please list all current medications taken:
   _____

8. Does your child have a visual impairment? ☐ No ☐ Yes (detail below)
   Date tested: _____ Results: _____

9. Does your child have a hearing impairment? ☐ No ☐ Yes (detail below)
   Date tested: _____ Results: _____

10. Has your child previously or currently had any of the following? Check all that apply, and provide detail for each:
    ☐ Food allergies: _____ ☐ _____ Medication allergies:
    ☐ History of seizures: _____ ☐ _____ Significant injuries:
    ☐ Surgeries (dates/type): _____ ☐ Hospitalizations: _____
    ☐ Ear infections (number of episodes since birth): _____ ☐ PE tubes (when): _____ Still in? ☐ No ☐ Yes

11. Does your child have any assistive medical equipment, such as walkers, orthotics, etc.? ☐ No ☐ Yes (list below)

PREVIOUS HISTORY OF THERAPY:

12. Has your child received therapy sessions in the past, or is he/she receiving therapy currently? ☐ No ☐ Yes (list below)

THERAPY TYPE	SESSIONS / WEEK	START DATE	END DATE	LOCATION (SCHOOL, CLINIC, IN-HOME)
PT				
OT				
ST				
ABA				
Chiropractic				

Patient name:	

TREATMENT AGREEMENT

I certify that the information given by me is correct. I authorize release of all records necessary for treatment and payment. I request that payment of authorized benefits be made in my behalf, directly to Burger Physical Therapy. I consent to and authorize this provider to administer all treatments and services that may be considered advisable in the judgment of my physician and in accordance with agency policies. In addition, I authorize (e.g. spouse, etc.) _____ to have access to my child's records.

CONFIDENTIALITY DURING TREATMENT

We protect your child's medical information as described under HIPAA guidelines and outlined in the attached notice of privacy practices for health information.

At this clinic, the majority of our treatments take place in the large open gym. Therefore, others may be able to hear information about your child's diagnosis and progress in therapy. You may always request to speak to your therapist privately. If you prefer that your child be treated in a separate area, we will be happy to arrange that for you. Please make your request prior to treatment.

Please note: If you wish to send your child to their therapy sessions with someone who is not their legal guardian, you must indicate this in writing.

☐ My child may be treated in the open gym. I understand I can always speak to his/her therapist privately.

☐ I would prefer that my child be treated in a separate area.

By signing this agreement, I understand and agree to the conditions stated above.

▶ _____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

▶ _____
PRINT NAME

BURGER
PHYSICAL THERAPY

Patient name:	

PARENTAL INVOLVEMENT

As your child is in physical, occupational and/or speech therapy, they will be experiencing new movements, new postures and alignments, and new sensory inputs in order to challenge them to meet their goals. These new experiences can be scary – not just for child, but also for all of us.

As your child is experiencing these new challenges, they may:

- cry
- refuse an activity
- act up
- avoid interaction
- verbalize not wanting to go to therapy

These are usually temporary and expected reactions to new experiences. As a parent, only you know how much is too much emotionally for your child to handle. If at any time during therapy you feel that the challenges are above your child's comfort level, you may:

- calm your child
- give your child a rest time
- shorten the therapy session
- ask for the session to end
- ask for that part of the session to end or be omitted

SIBLING POLICY

Due to the dangers in the clinic with swings and other equipment, along with the distractibility of some of our patients, **siblings are not allowed in the open gym unless they are seated in a chair, stroller, etc. and under the direct supervision of a parent**. Be aware that you may need to move if the area is needed by another child or therapist.

Please be respectful that some children we treat are extremely sensitive to noises and are highly distractible. If siblings are/or their equipment present a problem for any of the patients, a therapist may direct you to another area of the gym or to the lobby. Any therapist may request that a child be removed from the open gym if necessary. If a child is unsupervised anywhere in the clinic, a staff member will request parental supervision.

You are welcome to attend your child's full therapy session, but siblings must be seated at all times. Otherwise, you may enter the gym at the end of your child's session to share information with staff, with any siblings in your direct custody.

We want your child's therapy experience to be pleasant and productive, so it is necessary that both parents and therapists are aware of the effects other children may have on patients. Thank for your assistance in this matter. – Burger Pediatric Staff

By signing this agreement, I understand and agree to the conditions stated above.

▶ _____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

▶ _____

PRINT NAME

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact our HR Director at **1-800-597-5627**.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your lights to access and control your protected health information. Protected Health Information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices, by calling our office and requesting that a revised copy be mailed to you or asking for one at the time of your next visit.

PROTECTED HEALTH INFORMATION, USE AND DISCLOSURES:

Your protected health infomay be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to payers of your health care bills and to support the operation of our practice.

Following are examples of the types of use and disclosure of your protected health care Information that our office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of use and disclosure that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits; reviewing services provided to you for medical necessity; and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our Company. These activities include, but are not limited to, quality assessment activities, employee review activities, training of staff, licensing, and conducting business activities.

For example, we may disclose your protected health information to students that see patients at our office. We may call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We will share your protected health information with third party business associates that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health Information, as necessary, to provide you with information about treatment, case management, care coordination, or recommend treatment alternatives.

We may also use your name and address to send you announcements or newsletters about our practice and the services we offer. You may contact our Privacy Contact Person to request that these materials not be sent to you. ***You may opt out of this process by issuing this instruction in writing.***

We may use or disclose as needed, your protected health information for the treatment, payment and health care operations purposes of another covered entity, such as another provider, health plan or claim clearinghouse as long as they have a relationship with you.

USE AND DISCLOSURE BASED UPON YOUR WRITTEN AUTHORIZATION:

Other use and disclosure of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your therapist or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

USE AND DISCLOSURE WITH AUTHORIZATION OR OPPORTUNITY TO OBJECT:

We may use and disclose your protected health information in the fallowing instances: You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your therapist may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional Judgment.

We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that Is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate use and disclosure to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your therapist shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your therapist or therapist in the practice is required by law to treat you and the therapist has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your therapist or another therapist in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the therapist determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

USE AND DISCLOSURE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT:

We may use or disclose your protected health information in the following situations without your authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect, or domestic violence, to the governentity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post-marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include: (1) legal processes and otherwise required by law; (2) limited information requests for identification and location purposes; (3) pertaining to victims of a crime; (4) suspicion that death has occurred as a result of criminal conduct; (5) in the event that a crime occurs on the premises of the practice; and (6) medical emergency (not an the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.

We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaver organ, eye or tissue donation purposes.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health inform of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers Compensation: Your protected health information may be disclosed by us as authorized to comply with workers compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your therapist created or received your protected health information in the course of providing care to you.

Required Use and Disclosure: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

YOUR RIGHTS:

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights: You have the right to inspect and copy your protected health Information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A designated record set contains medical and billing records and any other records that your therapist and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be subject to review. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact Person if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. ***If you pay cash in full (out of pocket) for your treatment, you may instruct us not to share information about your treatment with your health plan. You must issue this instruction in writing.*** You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your therapist is not required to agree to a restriction that you may request. If your therapist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your therapist does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your therapist. **You may request a restriction by submitting a detailed written request, identifying the information you do not want disclosed and to whom you do not want it disclosed.**

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact Person.

You have the right to request that your therapist amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact Person to determine if you have questions about amending your medical record.

We are committed to protecting your health information. If there is a breach (as defined by law) of your PHI, we will notify you (as required by law) in written form by first-class mail, or alternatively, by email if the affected individual has agreed to receive such notices electronically.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations. You have the right to obtain a paper copy of this notice from us, upon request.

COMPLAINTS:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact Person of your complaint. We will not retaliate against you for filing a complaint.

You may contact our HR Director, in writing at 1301 E. Bidwell St., Folsom, CA 95630, or by telephone at 1-800-597-5627 for further information about the complaint process.

Updated and is effective on 12/6/17

BURGER PHYSICAL THERAPY

BE INFORMED
KNOW YOUR INSURANCE BENEFITS

Patient name:	

You are responsible for charges incurred during the course of treatment. As a courtesy, we will contact your insurance company in order to verify your benefits and your applicable copayment, deductible and/or coinsurance amounts. This is an estimate provided by your insurance carrier to us. It is only upon claim submittal and processing (which can take up to 90 days or more) that we are informed by your insurance company of the actual portion you owe of your treatment cost. It is ultimately your responsibility to inform yourself of your insurance benefits, limitations and financial responsibilities. We assume no liability for inaccurate benefit quotations made by your insurance carrier in our verification process. Please contact your insurance company if you have questions regarding your coverage. You may also contact our billing office if you determine any discrepancies or have any questions: call (916) 351-1083 or email Billing@BurgerRehab.com.

Thank You,
Burger Physical Therapy

By signing this agreement, I understand and agree to the conditions stated above.

▶ _____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

▶ _____
PRINT NAME

BURGER PHYSICAL THERAPY

CONSENT

PATIENT NAME	

AUTHORIZATION TO RELEASE PAYMENT & PATIENT INFORMATION

We protect your medical information as described under HIPAA guidelines and outlined in the attached notice of privacy practices for health information. In addition, I authorize e.g.: (Spouse, etc.) _____, to have access to my records.

Within a clinic setting some patients may receive their treatment within a large area (e.g. gym, pool, and hand therapy room), therefore, another patient may be able to hear information about a patient's diagnosis or progress in therapy. You will always be able to speak privately with the therapist. If you prefer to be treated in a separate area, we will be happy to arrange that for you. Please make your request known prior to your treatment.

I certify that the information given by me is correct. I authorize release of all records necessary for treatment and payment. I request that payment of authorized benefits be made in my behalf, directly to Burger Physical Therapy & Rehabilitation Agency, Inc. I consent to, and authorize the Rehabilitation Agency to administer all treatments and services that may be considered advisable in the judgment of my physician in accordance with agency policies.

CANCELLATION & NO-SHOW POLICY

Please arrange your appointments with the receptionist. The receptionist will provide you with an appointment card for your convenience. Your appointment is **reserved** for you. **Any cancellations should be called into our office at least 24 hours in advance or you may be charged $50.00 for the appointment. No-shows will be charged $50.00 for the appointment. You will be required to pay the $50.00 for your missed appointment on your next visit. If an interpreter is arranged for you by us for your appointment and you do not give the required 24 hours notice of a cancellation or you no-show for your appointment, you will be required to pay $150.00 for your missed appointment prior to scheduling your next visit. Your insurance will not pay this. It is your responsibility.** Telephone lines are open 24 hours with a recorder. **Consecutive "no shows" can cause you to lose your time slot for follow-up appointments.** If the occurrence involves a Workers' Compensation case, the carrier will be notified of failure to attend therapy

PAYMENT AGREEMENT

We will bill your primary insurance carrier; however, all bills are due and payable within 30 days. Patients are financially responsible for all charges incurred during treatment, regardless of expected reimbursement by insurance. By signing this, I understand and agree that if my insurance carrier or other party makes payments to me or to my representative for my treatment, I agree to immediately remit those funds to Burger Physical Therapy and Rehabilitation Agency, Inc.

By signing this, I understand and agree that if my account becomes past due, I will be charged a pre-collect processing fee of $35. I also understand and agree that if my account is turned over to a collection agency or an attorney for collections, I am responsible for all costs of collecting monies owed including, but not limited to, collection agency fees, court costs and attorney fees.

CO-PAYMENT POLICY: Co-payments are a fixed fee determined by your insurance plan and must be paid at the time of service. If you have a co-payment and Medi-Cal is your secondary insurance, you will be required to pay your copay at the time of service as we are not a Medi-Cal contracted provider.

PAYMENTS BY CHECK: When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and you will not receive your check back from your financial institution.

WORKERS' COMPENSATION POLICY: We will accept most Workers' Compensation cases. It is to be understood by the patient if, for any reason, the case is denied by the Workers' Compensation carrier, the patient will be totally responsible for the bill and the account must be paid off within 60 days of the date it was denied.

CHANGES IN INSURANCE: We have agreed to bill your insurance for the services provided in the course of your care. Due to increasingly specific benefits and requirements conditional for reimbursement, it is imperative that you notify the office immediately when your coverage changes. Failure to do so could result in you being responsible for the bill

By signing this agreement, I understand and agree to the conditions stated above.			
_____ **Signature of Patient or Responsible Party**	_____ **Print Name**	**Date**	

BURGER PHYSICAL THERAPY

BILLING INFORMATION

CLINIC:	**ACCOUNT #:**
THERAPIST:	**START DATE:**

PATIENT INFORMATION

PATIENT			
ADDRESS			
CITY/STATE/ZIP			
DATE OF BIRTH		☐female ☐male	
PHONE:HOME #		WORK #	
CELL #		Preferred # ☐Home ☐ Work ☐Cell	
SSN			
EMPLOYER			
ADDRESS			
CITY/STATE/ZIP			
SPOUSE			
SSN			
EMPLOYER			
ADDRESS			
CITY/STATE/ZIP			
EMAIL			

PARENT INFORMATION (minors only)

PARENT/GUARDIAN			
ADDRESS			
CITY/STATE/ZIP			
PHONE:HOME #		WORK #	
SSN			
EMPLOYER			
ADDRESS			
CITY/STATE/ZIP			
PARENT/GUARDIAN			
ADDRESS			
CITY/STATE/ZIP			
PHONE:HOME #		WORK #	
SSN			
EMPLOYER			
ADDRESS			
CITY/STATE/ZIP			

PRIVATE HEALTH INSURANCE

PRIMARY INSURANCE	
MEDICAL GROUP (if any)	
INSURED'S NAME	
RELATIONSHIP	☐self ☐spouse ☐parent
ID #	
GROUP #	
COPAYMENT	
SECONDARY INSURANCE	
MEDICAL GROUP (if any)	
INSURED'S NAME	
RELATIONSHIP	☐self ☐spouse ☐parent
ID #	
GROUP #	

WORKERS' COMPENSATION (if applicable)

COMP CARRIER			
CLAIM ADDRESS			
CITY/STATE/ZIP			
EMPLOYER			
CLAIM #		DOI #	
ADJ/CASEWORKER			
PHONE #		FAX #	

MOTOR VEHICLE ACCIDENT (if applicable)

AUTO INSURANCE			
CLAIM ADDRESS			
CITY/STATE/ZIP			
INSURED			
CLAIM #		DOI #	
CLAIMS ADJUSTER			
PHONE #		FAX #	

PCP			
PHONE #		**FAX #**	
REFERRING MD			
PHONE #		**FAX #**	

DIAGONOSIS	
DATE OF INJURY	