Personal Injury Claim Intake Form

Stow-Kent Chiropractic Clinic, Inc.
Dr. Michael A. Shimmel, Clinic Director

Confidential Patient Information

Date ___/___/___

Name _____ Sex ___ Age ___ Home Phone _____

Address _____ City _____ State ___ Zip Code _____

Cell Phone _____ Email _____

Social Security # _____ Birth Date ___/___/___

Marital Status M S W D (Please Circle One) How many children? _____

Employer _____ Occupation _____

Address _____ Office Phone _____

Insurance Company _____ Policy # _____

Name of Spouse _____ Occupation _____

Employer _____ Office Phone _____

Patient's Nearest Relative _____ Relation _____

Address _____ City _____ State ___ Zip Code _____

Referred By _____

Please list the dates and reasons you have been hospitalized (as well as can be remembered): _____

_____

Name of Person Responsible for Payment _____

I understand that Stow-Kent Chiropractic Clinic, Inc. will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Stow-Kent Chiropractic Clinic, Inc. will be credited to my account upon receipt. However, I clearly understand that, ultimately, I am personally responsible for payment. I also understand that payment for all professional services rendered to me is due and payable in full on the *earlier* of the following dates:

Exactly one (1) year from the date I started receiving services under this PI claim
OR
Exactly six (6) months from the date I received my last service under this PI claim

In signing this form, I agree to these terms for prompt payment despite any attorney involvement that might arise due to this claim, lack of settlement agreement between any involved insurance company and myself, unsuccessful litigation, or any other situation that might otherwise delay payment. Pending settlement and awaiting a check for settlement DO NOT relieve you of your duty to promptly pay for services in full in compliance with this agreement.

Patient/Guarantor Signature _____

STOW-KENT CHIROPRACTIC, INC.
DR. MICHAEL A. SHIMMEL D.C.
2991 GRAHAM RD.
STOW, OHIO 44224
330-686-1333

NAME: _____ DATE: _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the physicians at Stow-Kent Chiropractic Clinic to release any information acquired in the course of my examination or treatment.

_____
Signature

AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize payment directly to the physicians at Stow-Kent Chiropractic Clinic for all chiropractic and/or medical benefits. I understand that I am financially responsible for the charges not covered by this authorization.

_____
Signature

HIPAA HAPPENINGS

This notice describes how your health information may be used and how you can gain access to this information. Please review it carefully.

Our Promise to You our Valued Patient...

This is not meant to alarm you. Quite the opposite. We want to assure you that we take the new Federal HIPAA (Health Insurance Portability and Accountability Act) laws seriously. These laws are written to protect the confidentiality of your health information. We trust you will never delay treatment in our offices because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

Why a Privacy Policy Now?

The most significant variable that has motivated the Federal government to legally enforce the privacy of health information is the rapid evolution of the use of electronic technology in the administration of health care business. The government has appropriately sought to standardize and protect the electronic exchange of your health information. This has challenged us to review not only how your information is used within our computers, but also with the Internet, phones, fax machines and any device used to copy or transfer that data.

We want to advise you that we have developed policies and procedures for our practice to assure that your personal or health information will be shared only as required and only for the purpose of administering your case. Our office is subject to State and Federal laws regarding the confidentiality of your health information. We will assure our adherence to those laws and we want you to understand our procedures and your rights as a valued patient. Your health information will be communicated only for the purpose of conducting health care business and obtaining payment for services. Be assured that without your written permission, your health information will not be used for any other purpose.

How your Health Information May Be Used to Provide Treatment

Within our offices, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all the office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories or other health professionals providing you treatment.

To Obtain Payment

Your health information may be included with an invoice for the purpose of collecting payment for services provided to you in this office. We may do this with insurance forms filed for you by mail or electronically. We will make every effort to work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experience by patients receiving care in our office. As a result, your health information may be included in the training programs for students, interns, and associates, as well as business and clinical employees. It is also possible that your health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or members of your family. These communications are an important part or our philosophy of partnering with our patients to be sure they receive the best care chiropractic can provide. They may include postcards, newsletters, flyers, and telephone or electronic reminders such as email (unless you tell us that you prefer not to receive reminders.)

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security.

For Law Enforcement

As permitted or required by state or Federal law, we may disclose your health information to proper authorities for the purpose of law enforcement including, under certain circumstances, if you are a victim or a crime or in order to report a suspected crime.

Family, Friends, and Caregivers

We may share your health information with those you tell us will be assisting you with your home hygiene, care, treatment or payment. We will be certain to obtain your permission prior to sharing your information. In the event of an emergency, if you are unable to tell us what you want, we will use our very best judgment when sharing your health information with anyone participating in your care.

Medical Research

Advancing health care knowledge often involves learning from the careful study of health histories or prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements, and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Rights

This law is careful to describe that you have the following rights related to your health information. Be assured that our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Information

You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information privately with or without family members present or through sealed mail communications. We will make all reasonable effort to honor your request.

Inspect and Copy Your Health Information

You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe as completely as possible your reason for the request.

Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information have been requested sealed and or delivered to any authority for review.

Documentation of Health Information

You have the right to request from us a description of how and where your health information was used by our office for any reason other than for treatment or payment, or health care operations. Our documentation procedures will enable us to provide information on your health information usage from April 14th, 2003 and forward. Please let us know in writing the time period for which you are interested. We will greatly appreciate you limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time. Just let us know of your request. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our notice. Patients would be notified of any such changes.

You have the right to express concerns of complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing, any concerns you may have regarding the privacy of your health information.

Patient Acknowledgment

Patient Name(s): _____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have questions, please let us know. If not, we would appreciate your acknowledging by signature that you have received, thoroughly reviewed and understand this policy.

_____ Date __/__/__

Patient Signature

Stow-Kent Chiropractic Clinic, Inc.
Dr. Michael A. Shimmel
2991 Graham Road
Stow, Ohio 44224

WORKERS' COMPENSATION ACKNOWLEDGMENT

I do hereby acknowledge that I am receiving (or am about to receive) health care services at the Stow-Kent Chiropractic Clinic, Inc. due to an industrial work injury. I have been advised that the doctor providing the services is willing to wait for payment for these services, provided that my managed care organization (MCO) and the bureau of workers compensation (BWC) approves these visits.

I understand that in case my MCO or the BWC denies the recommended treatments, I must provide the clinic with my health insurance information upon the onset of care. My health insurance will not be billed unless my MCO or the BWC denies the services and the claim then becomes a liability. If my MCO or the BWC denies treatment and I do not have health insurance coverage at the time of service, I understand I am liable for the outstanding balance and I will pay the balance in full upon notice of the denial.

If I have an existing claim, I understand that I am being held responsible to provide Stow-Kent Chiropractic, Inc. with my MCO information, the date of injury, and my claim number. If I have a new claim, I understand that I am being held responsible to provide Stow-Kent Chiropractic Clinic, Inc. with my MCO information and the date of injury. This information is necessary in order for the clinic to collect money due for services rendered to me. If I fail to provide the clinic with this information within 24 hours after my initial visit, I will be held liable for payment as the services are rendered.

I understand and agree with the above conditions. I also agree and understand that there will be a $5.00 missed appointment fee if I should fail to call and cancel an appointment. This fee will be due and payable on my next scheduled visit.

Dated the _____ day of _____, 19 _____

_____

Patient's Signature

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

BWC
Better Workers' Compensation
Built with *you* in mind.

INSTRUCTIONS:
- Please print or type
- Please send to the Service Office where your claim is located

Injured worker name (first, M.I., last)		Date of injury	Claim number
Address	City	State	9-digit ZIP Code
Employer name			

I, the above named injured worker, understand that I am allowing any person or facility that attends, treats, or examines me to release all medical, psychological, and/or psychiatric information that is related to my workers' compensation claim.

This information will be available to the Ohio Bureau of Workers' Compensation (BWC) or their agents, the Ohio Industrial Commission, and the above named employer, upon request.

I understand that a copy of the medical information received by the employer will be forwarded to BWC, by the employer.

I also understand that a copy of the medical information will be available to me or my physician of record upon request to BWC, the employer or provider.

Injured worker signature	Date

Ohio | Bureau of Workers' Compensation

First Report of an Injury, Occupational Disease or Death

By signing this form, I:

- **Elect to only receive compensation and/or benefits that are provided for in this claim under Ohio workers' compensation laws;**
- **Waive and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury or occupational disease, or death resulting from an injury or occupational disease, for which I am filing this claim;**
- **Agree that I have not and will not file a claim in another state for the injury or occupational disease or death resulting from an injury or occupational disease for which I am filing this claim;**
- **Confirm that I have not received compensation and/or benefits under the workers' compensation laws of another state for this claim, and that I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.**

WARNING:
Any person who obtains compensation from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements or accepting compensation to which he or she is not entitled, is subject to felony criminal prosecution for fraud.

(R.C. 2913.48)

Injured worker and injury/disease/death info.

Last name, first name, middle initial		Social Security number	Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Date of birth
Home mailing address		Sex ☐ Male ☐ Female		Number of dependents
City	State / 9-digit ZIP code	Country if different from USA		Department name
Wage rate $ _____ Per: ☐ Year ☐ Other _____ ☐ Hour ☐ Month ☐ Week		What days of the week do you usually work? ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat		Regular work hours From _____ To _____
Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers' Compensation? ☐ Yes ☐ No If yes, please explain.				Occupation or job title

Employer name				
Mailing address (number and street, city or town, state, ZIP code and county)				
Location, if different from mailing address				
Was the place of accident or exposure on employer's premises? ☐ Yes ☐ No (If no, give accident location, street address, city, state and ZIP code)				
Date of injury/disease	Time of injury _____ ☐ a.m. ☐ p.m.	If fatal, give date of death	Time employee began work _____ ☐ a.m. ☐ p.m.	Date last worked / Date returned to work
Date hired	State where hired	Date employer notified	State where supervised	

Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death.)	Type of injury/disease and part(s) of body affected (For example: sprain of lower left back)

Benefit application release of information – I am applying for a claim under the Ohio Bureau of Workers' Compensation Act for work-related injuries that I did not inflict. I affirm that I elect to receive compensation and benefits under Ohio's workers' compensation laws for my claim, and I waive and release my right to file for and receive compensation and benefits under the laws of any other state for this claim. I request payment for compensation and/or medical benefits as allowable, and authorize direct payment to my medical providers. I permit and authorize any provider who attends, treats or examines me, the Ohio State Board of Pharmacy, the Ohio Department of Job and Family Services and the Ohio Rehabilitation Services Commission to release medical, psychological, psychiatric, pharmaceutical, vocational and social information. I understand this may include personally identifying information that is casually or historically related to my physical or mental injuries relevant to issues necessary for the administration of my claim to BWC, the Industrial Commission of Ohio, the employer in this claim, the employer's managed care organization and any authorized representatives. My previous or future BWC claims may affect decisions made in this claim. Proper administration of the present claim may require BWC to share claims information with the employers of record (or their authorized representatives) and/or my authorized representative for any and all such previous or future claims. The released claims information may include any record maintained in my claim files.

Injured worker signature	Date	E-mail address	Telephone number	Work number ( )

Treatment info.

Health-care provider name	Telephone number ( )	Fax number ( )	Initial treatment date
Street address	City	State	9-digit ZIP code
Diagnosis(es): Include ICD code(s)			
Will the incident cause the injured worker to miss eight or more days of work? ☐ Yes ☐ No	Is the injury causally related to the industrial incident? ☐ Yes ☐ No		
E code	11-digit BWC provider number	Date	
Health-care provider signature			

Employer info.

Employer policy number	Check if ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm			
Telephone number ( )	Fax number ( )	E-mail address	Federal ID number	Manual number
Was employee treated in an emergency room? ☐ Yes ☐ No	Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No			
If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code				

☐ **Certification** - The employer certifies that the facts in this application are correct and valid.

☐ **Rejection** - The employer rejects the validity of this claim for the reason(s) listed below:

For self-insuring employers only

☐ **Clarification** - The employer clarifies and allows the claim for the condition(s) below:
☐ **Medical only** ☐ **Lost time**

Employer signature and title	Date	OSHA case number

This form meets OSHA 301 requirements