SYNERGY
HEALTH PARTNERS

PATIENT INTAKE – WORKERS COMPENSATION

PATIENT PERSONAL INFORMATION

LAST NAME:			FIRST NAME:	
DATE OF BIRTH:	AGE:	SOCIAL SECURITY #:	DRIVER LICENSE #:	YEARS OF SCHOOL COMPLETED:
ADDRESS:		CITY:	STATE:	ZIP:
HOME PHONE: ( )	MOBILE PHONE: ( )		WORK PHONE: ( )	
MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Widowed		GENDER: ☐ Male ☐ Female		

EMERGENCY CONTACT INFORMATION

FULL NAME:	RELATIONSHIP TO YOU:
PHONE: ( )	MAY WE LEAVE A VOICE MAIL AT THIS NUMBER? ☐ Yes ☐ No

INSURANCE INFORMATION

☐ Primary Health Insurance ☐ Automobile Accident ☐ Workers' Compensation	☐ Secondary Health Insurance ☐ Medicare ☐ Medicaid
INSURANCE NAME:	GROUP NAME / NUMBER:
POLICY HOLDER NAME:	POLICY NUMBER:
INSURANCE COMPANY PHONE: ( )	CO-PAYMENT: $
Do you have an attorney? **Have they advised you to seek care outside the WC system?** **Did the Atty prevail on a request for change of ATP under Rule 8?** **If Yes, did the employer fail to comply with Rule 8?** **Is there a General Admission of Liability?** **Is there a Notice of Contest (Denying liability)?**	**Did you report the Injury to your Employer?** **Did the Employer report the injury to the WC insurance carrier?** **Did your employer five you a list of at least four medical providers to choose from?** **If Yes, have you started treatment with them?**

EMPLOYER INFORMATION

EMPLOYER'S NAME:		OCCUPATION:	
EMPLOYER'S ADDRESS:	CITY:	STATE:	ZIP:
EMPLOYER'S PHONE: ( )	SUPERVISOR'S NAME:		

By signing below, I affirm that the answers provided by me on this questionnaire are true and accurate to the best of my knowledge.

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Signature of Patient: _____ **Date:** ____/____/_____
*(or Responsible Party)*Relationship (*If Other Than Patient*): _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

SECTION A: **This entire section must be completed for all PHI or Right to Access.**		
PATIENT'S FULL NAME:	**DATE OF BIRTH:**	**SOCIAL SECURITY NUMBER:**
PATIENT'S STREET ADDRESS:	**REQUESTOR'S NAME:**	
PATIENT'S CITY / STATE / ZIP:	**REQUESTOR'S ADDRESS:**	
PATIENT'S PHONE NUMBER: **( )**	**REQUESTOR'S PHONE NUMBER:** **( )**	**REQUESTOR'S FAX NUMBER:** **( )**
PURPOSE OF DISCLOSURE: ☐ Worker's Compensation ☐ Physical ☐ Drug Screen ☐ Other	**RECORDS REQUESTED FROM:**	
	ADDRESS:	
	PHONE NUMBER: **( )**	
RECORDS REQUESTED FROM: **DATE: ____/____/_____**	**EVENT:**	

SECTION B: **Description of information to be used or disclosed.**		
DESCRIPTION:		
☐ All PHI in Medical Record	☐ Laboratory	☐ History and Physical
☐ Other:		

SECTION C: **Signatures.**	
• *I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, or other health information,* • *I have read the above and authorize the disclosure of Protected Health Information (PHI) as stated.*	
SIGNATURE OF PATIENT:	**DATE:**

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PATIENT CONSENT FORM

I, _____, the undersigned, hereby consent to the following:

- Administration and performance of all treatments;
- Administration of any needed anesthetics;
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient;
- Use of prescribed medication;
- Performance of diagnostic procedures/tests;
- Taking and utilization of cultures;
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.

✓ I fully understand that this is given in advance of any specific diagnosis or treatment.

✓ I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks. No guarantees have been made to me as to the results of my treatment with Synergy Health Partners, and I understand that these aforementioned entities encourage me to ask questions and voice concerns about medical care or services which does not compromise my care.

✓ I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until treatment is discharged.