CONFIDENTIAL HEALTH INFORMATION

Eddy Chiropractic Clinic Inc.
443 Highland Ave
Williamstown, WV 26187
304-375-6000

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
○ No ○ Yes When?

Whom may we thank for referring you?

If so, whom?

Gender
○ Male ○ Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Marital Status
○ Single ○ Married ○ Divorced
○ Widowed ○ Separated

Address

City

State/Province

ZIP/Postal Code

Home Phone

Spouse's Name

Email Address

Cell Phone

Child's Name and Age

Emergency Contact

Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

May we contact you at work?
○ Yes ○ No

Address

State/Zip

Phone

Preferred method of contact?
○ Home Phone ○ Cell Phone
○ Work Phone ○ Email

PRIMARY INSURANCE INFO

Insured's Last Name

Birth Date (MM/DD/YY)

Insured's Social Security #

Insured's First Name

Middle Name (or Initial)

Who carries this policy?
○ Self ○ Spouse ○ Parent

SECONDARY INSURANCE INFO

Insured's Employer

Employer's Phone

Insured's Last Name

First Name

Middle Initial

Birth Date

Social Security #

Address

City

State/Province

ZIP/Postal Code

Relationship to patient

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. And are the result of (darken circle): ◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _____

3. Onset (When did you first notice your current symptoms?)

_____

4. Intensity (How extreme are your current symptoms?)

0 ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 10

Absent Uncomfortable Agonizing

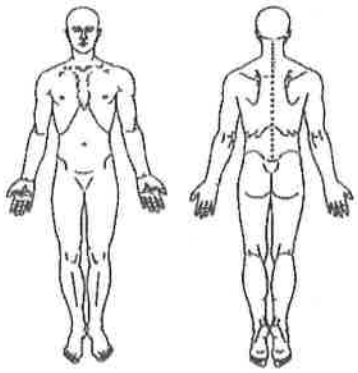
5. Duration and Timing (When did it start and how often do you feel it?)
◯ Constant ◯ Comes and goes. How Often? _____

_____

6. Quality of symptoms (What does it feel like?)

- ◯ Numbness
- ◯ Tingling
- ◯ Stiffness
- ◯ Dull
- ◯ Aching
- ◯ Cramps
- ◯ Nagging
- ◯ Sharp
- ◯ Burning
- ◯ Shooting
- ◯ Throbbing
- ◯ Stabbing
- ◯ Other _____

7. Location (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

◯ Prescription medication	◯ Surgery	◯ Ice
◯ Over-the-counter drugs	◯ Acupuncture	◯ Heat
◯ Homeopathic remedies	◯ Chiropractic	Other _____
◯ Physical therapy	◯ Massage	_____

11. What else should Eddy Chiropractic Clinic know about your current condition? _____

_____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right. **Are you currently treating with a Primary Care Physician Y N**

Name of Physician: _____

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck pain	○	○	Back problems	○	○	Hip disorders
○	○	Knee injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○	○	Poor posture

NONE ○ Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and needles	○	○	Numbness

NONE ○ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor circulation	○	○	Angina	○	○	Excessive bruising

NONE ○ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia

NONE ○ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea

NONE ○ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○	○	Loss of taste

NONE ○ Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash

NONE ○ Initials ____

ADDITIONAL INFO

Height: _____

Weight: _____

Eddy Chiropractic Clinic Inc.

(Continued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy	Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms	Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○	○	Weakness	Initials ____

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: ____
○	○	Cancer			
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: ____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine ____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: ____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements:

List: ____

○ ○ Medications (prescription and over-the-counter): ____

17. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

18. Family History

Some health issues are hereditary. Tell Eddy Chiropractic Clinic about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother	____	○	○	____	____	○	○
Father	____	○	○	____	____	○	○
Sister 1	____	○	○	____	____	○	○
Sister 2	____	○	○	____	____	○	○
Brother 1	____	○	○	____	____	○	○
Brother 2	____	○	○	____	____	○	○
____	____	○	○	____	____	○	○

19. Are there any other hereditary health issues that you know about? ____

20. Social History

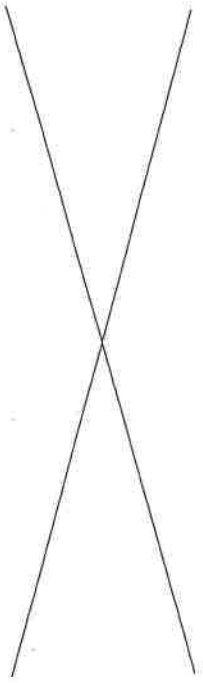
Tell Eddy Chiropractic Clinic about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much? ____	Prayer or meditation?	○ Yes	○ No
Coffee use	○ Daily	○ Weekly	How much? ____	Job pressure/stress?	○ Yes	○ No
Tobacco use	○ Daily	○ Weekly	How much? ____	Financial peace?	○ Yes	○ No
Exercising	○ Daily	○ Weekly	How much? ____	Vaccinated?	○ Yes	○ No
Pain relievers	○ Daily	○ Weekly	How much? ____	Mercury fillings?	○ Yes	○ No
Soft drinks	○ Daily	○ Weekly	How much? ____	Recreational drugs?	○ Yes	○ No
Water intake	○ Daily	○ Weekly	How much? ____			

Hobbies: ____

Please list all Medications



Eddy Chiropractic Clinic Inc.

21. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

22. What is the major stressor in your life? _____

23. How much sleep do you average per night? _____ **Hours**

24. What is the type and approximate age of your mattress and pillow? _____

25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

***CONSENT TO TREAT A MINOR CHILD**

Initials _____I hearby authorize the doctors and assistants at EDDY CHOROPRACTIC, Inc. to administer care as deemed nessessary to my (son / daughter) _____.

If the patient is a minor child, print child's full name: _____

Signature _____ **Date (MM/DD/YY)** _____

Eddy Chiropractic Clinic Inc.

CONSENT TO USE AND DISCLOSE OF HEALTH INFORMATION

By signing this form, you are granting consent to Eddy Chiropractic Clinic Inc. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices (NPP) provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at (304) 375.6000. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Authorization to Leave Messages with Household Members/Answering Machine

From time to time, it is necessary for representatives of Eddy Chiropractic Clinic Inc. to leave messages for patients. The purposes of these messages are to notify the patient that the doctor would like to discuss results, or to ask a patient to call Eddy Chiropractic Clinic, INC regarding an issue or concern, or to cancel/reschedule an appointment. At no time will a representative of Eddy Chiropractic Clinic discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Preferred phone number to be contacted: (_____)_____

_____approval to leave a message with detailed information

_____leave a message with call back number ONLY

_____ _____
Signature Date

_____
Patient Name (Please Print)

HIPAA FORM

If you would like the option of being able to have your spouse, parent, or other individual to discuss your account with us please fill in the form below and sign. If our office does not have signed permission by you, we will be unable to honor any request for information from any of these parties. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Names authorized on account (list relationship), if no one is authorized, write N/A below, mark No Consent.

Name:_____ Relationship to Patient: _____

Name:_____ Relationship to Patient: _____

Name:_____ Relationship to Patient: _____

___ Medical only
___ Financial only
___ All
___ No Consent

_____ _____
Patient Signature Date

_____
Patient Name (print please)

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____

Patient Date of Birth: _____ SS Number:_____

I authorize the use and disclosure of the above individual's health information as described below.

The following individual or organization is authorized to make the PHI disclosure.

_____
Physician/Facility

_____
Address

The type and amount of information to be used or disclosed is as follows (include dates where appropriate):

__ All medical records from (date _____ to (date) _____ ☐ All dates of service
__ Most recent history and physical
__ Most recent discharge summary
__ Office visits from (date _____ to (date) _____
__ Laboratory results from (date _____ to (date) _____
__ X-ray and imaging reports from (date _____ to (date) _____
__ X-ray and imaging disc from (date _____ to (date) _____
__ Consultation reports from (date _____ to (date) _____
__ Other _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and/or treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual organizations:

Eddy Chiropractic Clinic Inc.
443 Highland Avenue, Williamstown, WV 26187
Phone: (304) 375.6000 Fax: (304)375.6043

The use or disclosure for which this request is made is: Review of medical records for diagnosis and/or treatment.

I understand that I may revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to Eddy Chiropractic Clinic. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. ***This authorization will expire one year from the date signed.***

I understand that authorizing the disclosure of this individually identifiable health information (PHI) is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider, the released PHI disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal privacy regulations.

I hereby authorize the use or disclosure of my PHI as described below.

Signature of patient or patient's legal representative *(Form MUST be completed before signing.)* **Date**

Printed name of patient's representative:_____

Relationship to the patient:_____

EDDY CHIROPRACTIC CLINIC, INC.
Exercise Wellness Center
Dr. Steven L. Eddy
443 Highland Ave., Williamstown, WV 26187 • (304) 375-6000 • Fax (304) 375-6043

GOOD FAITH ESTIMATE & FINANCIAL RESPONSIBILITY WAIVER

In this office, our major concern is to assist you in maintaining overall good health. As a patient with insurance coverage, you should be aware that insurance policies can vary greatly in terms of coverage, limitations, covered services and referral requirements. **We strongly recommend that each patient contact his/her own insurance company to verify their individual coverages.** Per our contract with your insurance carrier, it is required that you, the patient, be personally responsible for the payment of your deductibles/copays/co-insurance and charges that may exceed your coverage, prior to receiving treatment.

If at any time you fail to present our office with your current insurance card(s), fail to secure any necessary referral to be seen in our office, do not have current authorization on record for treatment in our office, exceed visit limitations, or receive non-covered services, the charges incurred will become your responsibility.

Please refer to the list below for the pricing of common services offered in our office so that you are aware of what charges will apply in the event you are responsible. This is not a complete list of services/supplies, pricing can be obtained from any of our staff should you have further concerns.

SERVICES		STANDARD CHARGES (Insurance)	CHUSA DISCOUNT ($49 enrollment fee)	PATIENT OPTIONS (no enrollment fee - 1/1/22)
Examinations	99202/99212	$90.00/$80.00	$75.00/$65.00	$75.00/$65.00
Detailed Examinations	99203/99213	$140.00/$115.00	(Worker's Compensation & Personal Injuries)	
X-rays	Multiple codes	$110.00 and up	$30.00 per view taken	$30.00 per view taken
Spinal Manipulation	98940/98941/98942	$50.00/$60.00/$70.00	$40.00	$40.00
Electrical Stim.	97014	$35.00	$20.00	$20 .00
Ultrasound	97035	$35.00	$20.00	$20.00
Cold Laser	97039	$35.00	$20.00	$20.00
Extremity Manipulation	98943	$50.00	$35.00	$35.00

Charges may vary based on your diagnosis determined upon your visit. Our staff will be happy to assist you with any questions you may have about your insurance benefits.

I have read and agree to receive the care recommended and accept financial responsibility for services provided.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Form OIC-WC-1

West Virginia Workers' Compensation
Employees' and Physicians' Report of Occupational Injury or Disease

PLEASE PRINT OR TYPE

Section I — Employee's Claim Information

Insurer: **Third-Party Administrator:**

1. Name: (Last): (First): (M.I):

2. Address: **3. Telephone:** ( ) -

City: State: Zip: **4. Social Security No.:** - -

5. Date of Birth: ____/____/____ **6. Sex:** ☐ M ☐ F **7. Marital Status:**

8. Date of Injury or Last Exposure: ____/____/____ **Time:** ☐ a.m. ☐ p.m. **9. Time You Began Work on Date of Injury:** ☐ a.m. ☐ p.m.

10. Date You Stopped Working Due to Injury: ____/____/____

11. Have You Retired? ☐ yes ☐ no If "yes," what was the date you retired: ____/____/____

12. Employer's Name: Supervisor's Name:

Address:

City: State: Zip: Telephone: ( ) -

13. Job Title/Description:

14. Body Part(s) Injured:

15. Describe How Your Injury Occurred (Specify the cause, what you were doing, and equipment/objects involved):

16. Did Injury Occur on Employer's Property? ☐ Yes ☐ No Address where injury occurred:

17. Please Identify Any Witnesses to Your Injury:

I certify that the above is true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, I hereby authorize any physician, chiropractor, surgeon, practitioner or other healthcare provider, any hospital, including Veterans' Administration or governmental hospital, and medical service organization, any insurance company, any law enforcement or military agency, any government benefit agency including the Social Security Administration, or any other institution or organization to release to each other, any medical or other information, including benefits paid or payable, pertinent to this injury or disease, except information relative to the diagnosis, treatment and/or counseling for HIV/AIDS, psychological conditions, and/or alcohol or substance abuse, for which I must give specific authorization. A Photostat of this authorization shall be as valid as the original.

Employee's Signature: _____ **Date:** _____/_____/_____

Section II — All Information Must Be Completed by Initial Healthcare Provider

1. Name of Physician/Hospital: **2. FEIN/Social Security No.:** - -

3. Address:

City: State: Zip: **Telephone:** ( ) -

4. Date of Initial Treatment: ____/____/____ **5. Date Patient May Return to Work:** ____/____/____

6. Have you advised the patient to remain off work 4 or more days?

☐ Yes. Indicate dates: from to

☐ No. If "no," is the patient capable of ☐ Full Duty ☐ Modified Duty If the patient is capable of returning to modified duty, specify any limitations/restrictions:

7. Condition is a direct result of: ☐ Occupational Injury? ☐ Occupational Disease? ☐ Non-Occupational Condition?

8. Did this injury aggravate a prior injury/disease? ☐ Yes ☐ No. If Yes, explain:

9. Description of injury or occupational disease:

10. Body part(s) injured: **11. ICD-10-CM Diagnosis Code(s) in order of severity:**

12. Name of physician referred to: **13. If the patient was hospitalized, where?**

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly certify a false report or statement, withhold material fact or statement or knowingly aid or abet anyone attempting to secure benefits to which he or she is not entitled. In signing this form, I acknowledge I have been informed of my responsibilities under West Virginia's Workers' Compensation Law and agree to abide by such in the administration of services provided thereunder. I understand the submission of false statements or billing may result in prosecution under state and federal law. I further agree to release any office notes/test results immediately to the employer or their representative.

Signature: _____ **Date:** _____/_____/_____

WORKER COMPENSATION INFORMATION

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Soc. Sec.# _____

Address _____
Street City State Zip

Home Phone (____) _____ E-mail _____

Cell Phone (____) _____ Occupation _____

EMPLOYER

Employer Name _____

Employer Address _____
Street City State Zip

Employer Phone (____) _____ Injury Verified by (For Office Use) _____

Contact Person _____ E-mail _____

WORKER COMPENSATION CARRIER (FOR OFFICE USE)

Worker Compensation Carrier _____

Carrier Address _____
Street City State Zip

Carrier Phone (____) _____ Coverage Verified by _____

Adjuster's Name _____ Claim Number _____

INJURY INFORMATION

Date of Injury _____ Time _____ ☐ AM ☐ PM Place of Injury _____

Accident reported to employer? ☐ Yes ☐ No Name of person you reported accident to _____

Give full description of how accident happened _____

Have you lost time from work? ☐ Yes ☐ No How much? _____

Other doctors seen for this condition: Doctor's Name _____

Diagnosis _____ Were X-Rays taken? ☐ Yes ☐ No Other Tests? ☐ Yes ☐ No

If yes, by whom? Please list test(s) and result(s) _____

Any previous Worker Compensation injuries? ☐ Yes ☐ No Date(s) of previous injuries _____

Describe previous Worker Compensation injuries _____

AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Worker Compensation benefits is denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

BI-RCP/OO

11/06

Request for Change / Opt-Out

Return completed form to:
BrickStreet Mutual Insurance
P. O. Box 3151
Charleston, WV 25332-3151

☐ Change of Physician ☐ Opt-Out of Provider Network

1. Claimant's Name:
2. Claim Number:
3. Social Security Number:
4. Date of Injury:

I am requesting to: ☐ Change physicians to another network provider ☐ Seek treatment with an out-of-network physician
I am presently being treated by:
I am requesting to change to:
Address of requested physician (Street, City, State, Zip):
My reason for changing physicians or seeking treatment out of network:
I have checked with the requested physician to see if he / she will take me as a patient: ☐ Yes ☐ No

Claimant's Signature	Date