INJURY :: 1™

**Fax: 469-587-8440**

**PATIENT INFORMATION** TODAY'S DATE: _____ DATE OF INJURY (DOI): _____

PATIENT NAME: _____ GENDER: Male ☐ Female ☐

MAILING ADDRESS: _____

CITY:_____ STATE: _____ ZIP CODE: _____

PHYSICAL ☐ SAME AS ABOVE
ADDRESS (*IF DIFFERENT*):_____

CITY:_____ STATE: _____ ZIP CODE: _____

MAIN PHONE #: _____ ☐ Home ☐ Cell ☐ Other: _____

ALTERNATE PHONE #:_____ ☐ Home ☐ Cell ☐ Other: _____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____ AGE_____ SOCIAL SECURITY #: _____

***How did you learn of our clinic?*** *☐ Saw clinic sign c ☐ Phone book ☐ Internet ☐ Referred by Treating Dr. ☐ Referred by Attorney ☐ Referred by another patient ☐ Other*

_____

**INSURANCE CARRIER INFORMATION (IF APPLICABLE):**

INSURANCE NAME: _____ CLAIM #: _____

ADDRESS: _____ CITY:_____

STATE: _____ ZIP: _____ PHONE #:_____

ADJUSTOR: _____

**ATTORNEY INFORMATION:**

ATTORNEY NAME: _____

TEL#:_____ FAX #:_____

***PATIENT SIGNATURE***: _____ ***DATE***: _____

# ASSIGNMENT OF BENEFITS

**I, _____, hereby instruct and direct my insurance carrier or attorney to pay by check or electronic deposit of funds to: Texas Health LLC dba INJURY::1** for the professional and/or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional and/or medical services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS. This payment will not exceed my indebtedness to the above-mentioned assignee, and I agree to pay, in a current manner, any balance of said professional/ medical service(s) charges over and above this insurance payment,

**If my current policy prohibits direct payment to a provider or facility, I hereby instruct and direct Insurance Company to make out the check to me. I will endorse and mail or personally provide to INJURY::1 of Dallas**

- A photocopy of this assignment shall be considered as effective and valid as the original
- I authorize INJURY::1 of Dallas to deposit any check(s) received for payment on my account.
- I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case.
- I authorize Injury::1 of Dallas to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

AUTHORIZATION OF INSURANCE BENEFITS AND RIGHT OF RECOVERY

I hereby irrevocably assign and transfer to Injury::1 Treatment Center all rights, title and interest in the benefits payable for services rendered by Injury::1 Treatment Center, provided in my policy (ies) of insurance, but not construed to be an obligation of Injury::1 Treatment Center to pursue such recovery. Provided, however, this assignment and transfer shall not take away my standing to make claim or sue for benefits individually should coverage be denied by any insurance carrier(s). I will pay Injury::1 Treatment Center for all charges incurred or alternatively for all charges more than the sums actually paid following said policy(ies). I hereby authorize the insurance company(ies) listed in my coverage to pay directly to Injury::1 Treatment Center all benefits due to services rendered therein.

_____ _____

Signature of Patient/Policy Holder Date:

# INSURANCE PROTOCOL

**WORKER'S COMPENSATION:** We accept worker's compensation patients if they have reported the injury to their employer and they have a valid claim with their employer's designated carrier. We will never bill you for any services provided for the work injury unless the claim has been fully adjudicated (completed review) and has been found non-compensable (not a valid work injury). We will always attempt to assist you and try to answer any questions you may have regarding how the Worker's Compensation system works.

**MEDICARE**: Injury::1 Treatment Center is *NOT* a Medicare Participating Provider at this time. If you are a Medicare recipient, but still wish to have services provided at this facility, you will be responsible for payment in full for services rendered at the time of service.

**COMMERCIAL HEALTH INSURANCE/GROUP INSURANCE**: Before your initial evaluation, our office will verify your private health insurance benefits associated with an employer or group policy. You will be asked to sign a co-payment/deductible acknowledgement form. This will explain how much your insurance will cover and if there will be a co-payment or a deductible due. You will be expected to pay your co-pay prior to your visit unless other arrangements have been made. You will be issued a receipt upon payment.

**AUTOMOBILE INSURANCE:** Personal Injury Protection (PIP) usually pays at 80% of your medical bills, unless you have added the med pay option to your policy. Your insurance will be verified with your auto insurance carrier to determine coverage and the amount remaining. You will be given a co-pay sheet indicating the amount of coverage and/or deductible acknowledgement form to sign. If you have an attorney representing you for your accident, please provide the information on the patient information form. This office accepts Letters of Protection for personal injury claims. Copies of updated statements and medical records will be sent to your attorney. Injury::1 Treatment Center does NOT accept or file on Third Party Insurance.

We review our charges on an annual basis to ensure they are fair and competitive. As previously stated, we are willing to file your insurance for our services and will advise you if any problems arise. *Please note: a verification of insurance is not a guarantee of payment from the insurance company.* **Therefore, it is important for you to understand that you, the patient/responsible party, are ultimately responsible for the charges related to your therapy** (with the exception of Workers' Compensation as previously stated).

***If you are unable to make your appointment, please notify us a minimum of 12 hours in advance. Failure to provide ample notice may result in a charge to your account, which insurance will not cover.***

*Having read and understanding the above listed insurance information*:
I hereby authorize treatment of my present condition requiring physical medicine, rehabilitative therapy, and/or psychological treatment. I also authorize payment to be made directly to Injury::1.

_____ _____
Signature of Patient/Policy Holder Date

_____ _____
INJURY::1 of Authorized Representative Date

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# CONSENTS/ADMISSIONS

**AUTHORIZATION TO TREAT**: I hereby authorize Injury::1 Treatment Center and/or its licensed health care professionals and such assistants to evaluate and treat my condition; to render any and all medical care deemed necessary and any additional care and supplies that are recommended. I understand that the diagnosis or treatment of me by Injury::1 Treatment Center and/or its employees may be conditioned upon my consent and compliance.

**AUTHORIZATION TO RELEASE INFORMATION**: I consent to the use or disclosure of my protected health information by Injury::1 for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills, or to facilitate treatment planning. My protected health information means health information including any demographic information collected from me and created or received by my physician, another healthcare provider, an insurance plan, my employer or a healthcare clearinghouse. This protected information relates to my past, present or future physical and mental health condition(s) and identifies me, or there is reasonable basis to believe the information may identify me.

**THIRD PARTY LIABILITY**: Injury::1 Treatment Center does not believe that a liability case against a third party is reason to delay payment of services. I agree that payment for services rendered is not contingent upon any settlement judgment or verdict of which may eventually recover payment as a result of such liability cases. I agree to be ultimately responsible for payment in full for all services rendered in the event that a settlement is not reached or if my case is dropped by my attorney and I fail to contract with other legal counsel.

**RESPONSIBILITY AGREEMENT**: Although I have requested the provider to file with my insurance company on my behalf, I clearly understand that it is my responsibility to make sure any balance due at the end of ninety days from the date a claim is filed, be paid in full or payment arrangements be made with the Business Office.

**CIRCUMSTANTIAL RISK**: I have been made aware of the possible benefits, effects, and possible risk or complications associated with my care. I understand that I am able to seek other opinions relating to my health and that I may either accept or reject the treatment(s) prescribed to me. However, I understand that a rejection of and/or noncompliance with prescribed treatment(s) may have an adverse impact upon my case and/or jeopardize my ability to continue receiving services from Injury::1 Treatment Center and/or its providers.

*I have the right to revoke this consent in writing at any time, except to the extent that Injury::1 Treatment Center has taken action in accordance with this consent.*

*A photo static copy of this authorization shall be considered as effective and valid as original.*

*I have read and understand the above and agree to abide by these conditions.*

Patient Signature:_____ Date:_____

Witness Signature: _____ Date:_____

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## Medical Record Release Request

To release your medical records to a new provider or receive a copy for yourself or your attorney, you must complete this Medical Release form. Please fill it out completely and return it to us. If you should have any questions, please do not hesitate to contact our office.

I, _____(Patient Name)_____(SSN), _____, (DOB)

Hereby authorize the release of the following information:

- Most recent exam and tests
- All of my Medical Records, (including but not limited to treatment notes, reports or studies that were performed at your office)
- Other: _____

Please forward the documentation to:

Name of Provider: _____

Address of Institution or Provider: _____

I understand that the records are for the care, treatment or medical services provided to me, and retained by you are confidential and are being disclosed for the purpose of:

- Continuation of Care
- Litigation

I further understand that without this authorization, the provider would not be permitted to disclose this information, as indicated by law. I further understand these medical records cannot be faxed or transmitted electronically.

I recognize that I may revoke this consent at any time except to the extent that the information has already been released in reliance of this form. If not revoked, this consent will expire one year from the date signed.

I agree further not to sue or hold the provider of the information, its employees or agents, responsible for any issues, claims or causes of action arising out of the release of information in conformance with the terms of this release.

_____ _____

**Date** **Patient Signature (or Parent/Guardian if Patient is a Minor)**

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# PAIN INTENSITY RATING

Name: _____ Date:_____

On the line below, RATE your AVERAGE PAIN INTENSITY over this last week. Mark an "X" at the place on the line which best describes your pain.

0% 100%

No-----10-----20-----30-----40-----50-----60-----70-----80-----90----- Worst

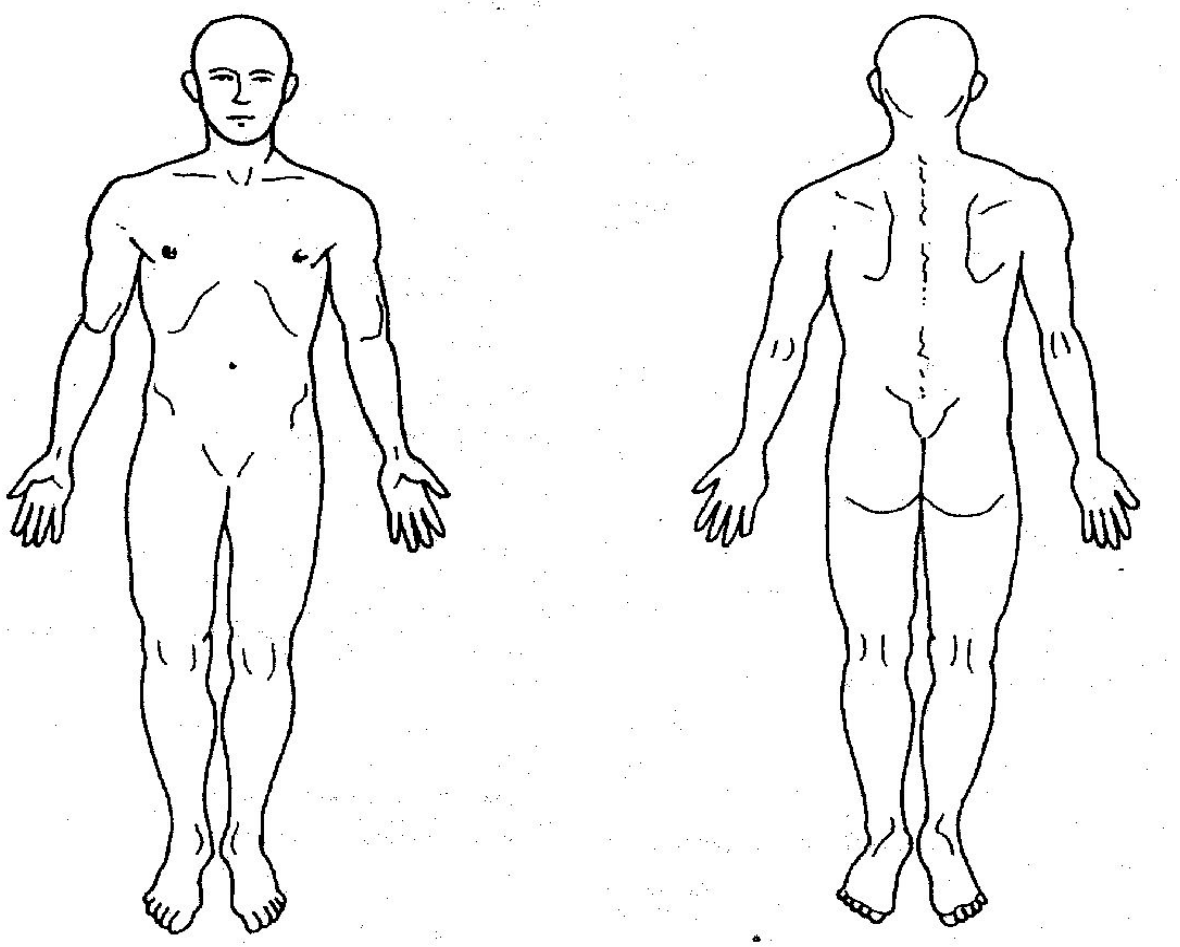
Pain Pain

## SHOW US WHERE YOU HURT

***Please read carefully*:** Mark all the areas on your body where you feel your pain as a result of your injury using the following symbols:

| Aches | Numbness | Pins & Needles | Burning | Stabbing |
|---|---|---|---|---|
| ^ | O | = | X | / |

If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels.



**PATIENT NAME:** _____ **DATE:** _____

NOMBRE DEL PACIENTE FECHA

**Date of Injury**: _____ **PATIENT SIGNATURE**:_____

*FECHA DE LESION* *FIRMA DEL PACIENTE*

***Patient Symptom Rating Scale ● Escala de evaluación de los síntomas:***

**Please circle the number on each scale below that **best** describes how you **CURRENTLY** feel.*
** Por favor ponga un círculo alrededor del número en cada escala que describe cómo se siente **AHORA**.*

***Pain Level ● Nivel de dolor***

1 2 3 4 5 6 7 8 9 10
Least / *Bien* Worst / *Muy Mal*

***Irritability/Restlessness ● Irritabilidad/Inquietud***

1 2 3 4 5 6 7 8 9 10
Least / *Bien* Worst / *Muy Mal*

***Frustration/Anger ● Frustración/Coraje***

1 2 3 4 5 6 7 8 9 10
Least / *Bien* Worst / *Muy Mal*

***Muscle Tension ●Tensión muscular***

1 2 3 4 5 6 7 8 9 10
Least / *Bien* Worst / *Muy Mal*

***Nervousness/Worry ● Nerviosismo/Preocupación***

1 2 3 4 5 6 7 8 9 10
Least / *Bien* Worst / *Muy Mal*

***Sadness/Depression ● Tristeza/Depresión***

1 2 3 4 5 6 7 8 9 10
Least / *Bien* Worst / *Muy Mal*

***Sleep Problems ● Problemas al dormir***

1 2 3 4 5 6 7 8 9 10
Least / *Bien* Worst / *Muy Mal*

***Forgetfulness ● Olvidadizo***

1 2 3 4 5 6 7 8 9 10
Least / *Bien* Worst / *Muy Mal*

***How many hours did you sleep last night? ● ¿Cuántas horas durmió Usted anoche?*** _____