

Workers Compensation
REGISTRATION/AUTHORIZATION FOR RELEASE OF INFORMATION

PLEASE PRINT

LAST NAME: _____ FIRST NAME: _____ M.I. _____

SOCIAL SECURITY #: _____ - _____ - _____

ADDRESS: _____ UNIT/APT #: _____

CITY: _____ STATE: _____ ZIP: _____

CELL PHONE: _____ - _____ - _____ DAY PHONE: _____ - _____ - _____

HOME PHONE: _____ - _____ - _____ EMAIL: _____

BIRTHDATE: ____ - ____ - ____ AGE: ____ GENDER: ____ MARITAL STATUS: ____

COMPANY NAME: _____ DATE OF HIRE: _____

JOB TITLE or POSITION NAME _____

JOB SITE: _____ JOB SHIFT: _____

SUPERVISOR NAME: _____ PHONE: _____

WORK COMP INSURANCE NAME /ADDRESS: _____

CLAIM #: _____

DATE OF INJURY: _____ TIME OF INJURY: _____

PLEASE DESCRIBE IN YOUR OWN WORDS HOW YOU BECAME INJURED:

BODY PART (S) INJURED: _____

WERE YOU SEEN ANYWHERE ELSE FOR THIS INJURY (like the ER/another PHYSICIAN)? NO YES*

*IF YES, WHERE AND WHEN:

I have been referred to Main Line HealthCare Occupational Health by the company named above for treatment of a work related injury or illness. By signing, I authorize treatment and release of my medical report for this injury/illness to my company's representative, insurance carrier and necessary medical providers.

SIGNATURE: _____ DATE: _____

WITNESS: _____ (print) _____ (sign) DATE: _____

WORKERS' COMPENSATION PATIENT FINANCIAL RESPONSIBILITY POLICY

(for patient completion)

Occupational and Travel Health physicians and staff are committed to providing you with the best possible care. We will be happy to discuss our professional fees with you at any time. Your clear understanding of our Financial Responsibility Policy is important to our professional relationship.

You are here today for treatment for a work related illness or injury. You need to do the following in order to ensure your claim is properly reported to your employer's workers' compensation insurance company. Timely reporting will facilitate payment of your claim.

- 1) Immediately (if you have not already done so) report this injury to your supervisor. Please ask our staff to allow you to use a telephone for that purpose.
- 2) Ask your supervisor to advise you of your claim number as soon as it becomes available.
- 3) Provide our office with that claim number as soon as it becomes available to you. Please call us at 484-476-8218, fax 610-993-0364, or e-mail to ziavrasa@mlhs.org.
- 4) If you are not provided with a claim number within seven (7) days of your injury, ask your supervisor the status of the claim. Continue to request that claim number from your supervisor.

We will bill your employer's workers' compensation insurance company. If the bill is not paid by your employer or their workers' compensation insurance company because your claim is denied or not properly reported by you, you will be responsible for payment. We do not participate with personal health insurance companies, therefore we cannot bill your personal insurance company, and you will be required to pay us directly. **A receipt will be provided that includes all of the required information for you to submit your claim to receive reimbursement from your personal insurance company.**

We accept cash, checks, and all major credit cards.

DELINQUENT ACCOUNTS

If your employer's insurance company does not pay the claim, and the bill becomes your responsibility, that account will be considered past due 30 days following our billing you, unless other arrangements have been made. Unpaid accounts beyond 90 days are considered delinquent, and may be forwarded to a collection agency.

RETURN CHECK FEE

There will be a transaction fee of \$25 for any check that is returned for insufficient funds.

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH, READ, AND UNDERSTAND THE PATIENT FINANCIAL RESPONSIBILITY POLICY STATED ABOVE AND I AGREE TO BE BOUND BY SAME.

Patient or Guarantor Name/ Signature

Date

Witness Name/Signature

Name: Last, First, Middle	Date of Birth	Gender : M F	Office Use Only: ☐ History Review only (no exam)
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Have you **EVER** had any of the following? (Check Yes or No for all conditions below).

Yes No		Yes No		Yes No		Yes No	
Anemia or Blood Disorder		Hepatitis		Injury/Trouble with:		Mumps	
Asthma		High Blood Pressure		Ankle		Rheumatic Fever	
Cancer/ Tumor		Kidney or Bladder Trouble		Back		Scarlet Fever	
Diabetes		Lung/Breathing Problems		Elbow		Whooping Cough	
Dental Problems		Malaria/ Tropical Disease		Foot		MEN ONLY: Prostate/ Testicular problems	
Drug/Alcohol Dependency		Migraines		Hand		WOMEN ONLY:	
Depression/Anxiety		Pneumonia		Hip		Irregular/ very painful periods	
Emotional/ Psychological Problems		Sexually Transmitted Disease		Knee		Disorders of Ovaries Uterus/breast	
Epilepsy/Seizures		Stomach Gastritis or Ulcers		Neck		Any Complications w/ pregnancy?	
Head Injury/ Concussion		Stroke		Shoulder		# of Pregnancies	
Hearing or Ear Problem		Thyroid Condition		Wrist		Date of Last Normal Period	
Heart Attack (Myocardial Infarction)		Tuberculosis		Chicken Pox		Date of Last Pelvic exam	
Heart Disease/ Murmurs		Recent Changes in Weight in last 6-12 months (>5 pounds)		German Measles		Date of Last Mammogram	
Heart Palpitation/ Abn Beat				Measles			

Please explain any "YES" answers (i.e. date, condition):

Yes No

☐* ☐ Do you smoke? Number packs per day _____ If former smoker, when did you stop? _____

☐ ☐ Have you had an allergic reaction to latex or natural rubber? _____

☐ ☐ Ever been a patient in a hospital or had any surgeries?(Include year and reason) _____

☐ ☐ Have you ever filed a workers compensation claim? _____

☐ ☐ Are you currently on any restrictions because of your health? _____

☐ ☐ Have you recently experienced any physical injuries/mental complaints? (If yes, state symptoms/signs) _____

☐ ☐ Do you have any condition(s) requiring a special work assignment? _____

☐ ☐ Do you use alcoholic beverages? ☐ Occasionally ☐ Daily (How much?) _____

☐ ☐ Do you exercise regularly?

☐ ☐ Have you had an allergic reaction during surgery, urinary catheterization, rectal, vaginal exam? (Circle)

☐ ☐ Have you been exposed to loud noise, dust, paint/solvents, welding fumes, vibrating tools, cancer causing chemicals, radiation irritants, gases or fumes during hobbies or employment?

List them: _____

☐ ☐ Do you have a family history of diabetes, high blood pressure, heart disease or cancer? _____

List all **Allergies** to Medications: ☐ None

List all **Medications**: ☐ None

I hereby certify that all information provided by me on this document is correct and complete to the best of my knowledge. I understand that I may ask the clinician questions. I agree to the tests that are necessary for this examination. I understand that I will be informed of the results of this examination.

Patient Signature _____ **Date:** _____

Physician/Physician Assistant/Nurse Practitioner comments on positive items above:

HCP Initials/Date	HCP Initials/Date	HCP Initials/Date	HCP Initials/Date
HCP Initials/Date	HCP Initials/Date	HCP Initials/Date	HCP Initials/Date



Main Line Health

Acknowledgement of Receipt of Notice of Privacy Notice

By signing below, I acknowledge receipt of the *Notice of Privacy Practices* of Main Line Health (“MLH”). In addition, by signing below, I authorize MLH to disclose my health information in conformance with the provisions of the Notice of Privacy Practices.

Signature of Patient

or

Signature or Personal
Representative

Patient Name – PRINT

Personal Representative’s Name- PRINT

Date / Time

Date / Time

Relationship to Patient

Inability to Obtain Acknowledgement

*(To be completed only if no
signature is obtained).*

No acknowledgement of receipt of Privacy Practices was obtained from the patient because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please specify):

Signature of MLH Representative

Date / Time

Rev. 07/13