PATIENT INFORMATION FORM

First Name: _____ M.I.:_____ Last Name: _____ DOB:_____

Address: _____City: _____State:_____ Zip: _____

Cell#: _____Alt.#: _____SS#:_____ Sex: ( ) M ( ) F
By providing a cell number, patient agrees to its use for calling and texting reminders.
( ) Check box if patient prefers to opt out of reminders by voicemail or text. Email: _____

Emergency Contact_____ Phone: _____

Employer: _____ Work Phone: _____

Location of Pain: _____

Cause of Pain: ( ) MVC State: _____ ( ) Work Injury ( ) Slip & Fall ( ) Pedestrian MVA ( ) Other

Date of Incident: _____ Did you go to hospital: ( ) yes ( ) no If yes, where? _____

X-Rays Taken: ( ) Yes ( ) No Previous MVC's: ( ) Yes ( ) No If yes, when? _____

Was MVC during work hours? ( ) Yes ( ) No Transportation Needed: ( )Yes ( ) No

AUTO/WORK INSURANCE INFORMATION

Insurance Name: _____ PCP Name: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Holder's Address: _____

Claim Number: _____ Adjuster: _____

Adjuster's Phone Number: _____ Extension: _____

Household Insurance:_____ Insured Name: _____

Health Insurance NOT Accepted

I understand that health and insurance policies are an arrangement between the insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all money will be credited to my account upon receipt. I state that all the above information is true and accurate.

Signature: _____ Date: _____

OFFICE USE ONLY

Referral: _____

Notes: _____

Driver/Passenger Claim Filed: Yes/No Owner: Yes/No

KENTUCKY NO FAULT

IMPORTANT:
A. TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE POLICYHOLDER'S INSURANCE CONTRACT, YOU MUST COMPLETE AND SIGN THIS FORM
B. YOU MUST ALSO SIGN THE ATTACHED AUTHORIZATION (S).
C. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

TO:_____
CLAIM DEPARTMENT

_____
NAME OF COMPANY

1. YOUR NAME | HOME PHONE NUMBER | BUSINESS PHONE NUMBER

2. YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE & ZIP CODE) | DATE OF BIRTH | SOCIAL SECURITY NO.

3. DATE AND TIME OF ACCIDENT A.M. P.M. | PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

4. BRIEF DESCRIPTION OF ACCIDENT

5. DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN A MOTOR VEHICLE? YES ☐ NO ☐

IF "YES," NAME OF INSURANCE COMPANY _____ POLICY NUMBER _____

WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	YES ☐	NO ☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	YES ☐	NO ☐
WERE YOU A PEDESTRIAN?	YES ☐	NO ☐
WERE YOU A MEMBER OF THE MOTOR VEHICLE OWNER'S HOUSEHOLD?	YES ☐	NO ☐
HAVE YOU REJECTED THE LIMITATIONS ON YOUR RIGHT TO SUE AS PROVIDED BY KENTUCKY NO-FAULT ACT (KRS 304.39)?	YES ☐	NO ☐

6. AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED?
YES ☐ (IF YOUR ANSWER IS "YES", COMPLETE THE REST OF THIS FORM.)
NO ☐ (IF "NO," SIGN HERE AND REURN THIS FORM TO US.)

_____ _____
Signature Date

7. DESCRIBE YOUR INJURY

8. WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐ | DOCTOR'S NAME AND ADDRESS

9. IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN-PATIENT ☐ OUT-PATIENT ☐ | HOSPITAL'S NAME AND ADDRESS

10. AMOUNT OF MEDICAL BILLS TO DATE $_____
WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐
AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐

11. DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES ☐ NO ☐

IF "YES," AMOUNT LOST TO DATE $_____

WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $_____

12. IF YOU LOST WAGES:
BEGINNING DATE OF DISABILITY FROM WORK: _____ DATE RETURNED TO WORK _____

1-2003

13. HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER
    1. ANY WORKMEN'S COMPENSATION LAW? YES ☐ NO ☐

       IF "YES," AMOUNT: $_____ PER WEEK ☐ PER MONTH ☐

    2. SOCIAL SECURITY BENEFITS? YES ☐ NO ☐

14. LIST NAMES & ADDRESSES OF YOUR EMPLOYER & OTHER EMPLOYERS FOR 1 YEAR PRIOR TO ACCIDENT DATE. GIVE OCCUPATION & EMPLOYMENT DATES.

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

I hereby authorize release of medical information, including but not limited to, medical bills and reports, to such persons as the company may deem necessary.

15. AS A RESULT OF YOUR INJURY, HAVE YOU HAD ANY OTHER EXPENSES? YES ☐ NO ☐
    IF "YES", explain:

WARNING

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

_____ _____
Signature Date

DO NOT DETACH

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS (KENTUCKY NO-FAULT) LAW.

_____ _____
Signature Date

DO NOT DETACH

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS (KENTUCKY NO-FAULT) LAW.

_____ _____
Signature Date

MAIL COMPLETED FORM TO:

KENTUCKY ASSIGNED CLAIMS PLAN
Suite 100, 10605 Shelbyville Road
Louisville, Kentucky 40223

1-2003

SUPPLEMENT TO THE "APPLICATION FOR BENEFITS"
For Claims Under the Kentucky Assigned Claims Plan Only

TO: KENTUCKY ASSIGNED CLAIMS PLAN
Suite 100, 10605 Shelbyville Road
Louisville, Kentucky 40223

YOUR NAME_____**DATE OF ACCIDENT**_____

ADDRESS_____**TELEPHONE NO:** _____

As a result of injuries receive in the accident, did you receive and are you entitled to receive any benefits including but not limited to:

A) Private Insurance? **Yes ( ) No ( )**

If "Yes", check type: Health ( ) Group ( ) Auto ( ) Other ( )

B) Government Benefits? (County, State or Federal) Yes ( ) No ( )

If "Yes" type: Social Security ( ) Medicare ( ) Workmen's Comp ( ) Other ( )

C) Other Gratuitous Benefits? Yes ( ) No ( )

Wage continuation plans or other benefits (describe)_____

D) Benefits Received From Any Other Source? Yes ( ) No ( )

Name and Address of organization and amount: _____

E) I am the owner of a motor vehicle. Yes ( ) No ( )

If answer is "YES", specify the name of the insurance company, if the motor vehicle was insured at the time of the accident

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Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

You are required to provide this information in accordance with the KRS304.39-160. This supplement must be accompanied by the Application for Benefits form.

Sign_____

Date_____

Witness_____

1-2003

HEALTH HISTORY FORM

NAME:_____ **DATE**:_____

Age: _____ **Height**: _____ **Weight**: _____ **Are or could you be pregnant?** ☐ Yes ☐ No ☐ N/A

List any injuries **PRIOR** to this accident and how it occurred _____

List body part(s) injured and approximate date of injury _____

Did you receive physical therapy for the injuries? ☐ Yes ☐ No Any ongoing issues related to the injury? ☐ Yes ☐ No

If yes, please describe _____

Primary Care Provider: _____ Phone: _____

MEDICAL HISTORY (please check all that apply and circle self or family)

☐Pacemaker	Self / Family	☐Diabetes	Self / Family	☐High Cholesterol	Self / Family
☐Heart Attack	Self / Family	☐Stroke	Self / Family	☐Osteoporosis	Self / Family
☐Heart Disease	Self / Family	☐Asthma	Self / Family	☐Arthritis	Self / Family
☐High Blood Pressure	Self / Family	☐Cancer	Self / Family	Type of cancer_____	
☐COPD/Emphysema	Self / Family	☐MRSA	☐Hepatitis A	☐Hepatitis B	☐Hepatitis C ☐HIV/AIDS

☐List any health issues you have _____

SURGERIES (list any surgeries with approximate year) _____

_____

MEDICATION (list any medication you have taken in the past 6 months) _____

_____

MEDICATION ALLERGIES (list any medication allergies, include reaction that happens) _____

_____

WORK HISTORY (what is your current work status) ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Disabled

Type of work _____ Have you worked since the accident? ☐Yes ☐ No

SOCIAL HISTORY

Do you have a history of drug/alcohol abuse? ☐ Yes ☐ No
Do you have a family history of drug/alcohol abuse? ☐ Yes ☐ No If yes, list who_____
Do you drink alcohol? ☐Yes ☐ No If yes, how often? _____
Do you smoke? ☐ Yes ☐ No If yes, how often? _____
Do you use chewing tobacco? ☐ Yes ☐ No
Do you use any illicit drugs, including marijuana? ☐ Yes ☐ No
If yes, please explain what drugs and how often _____
Have you traveled outside the United States in the last 12 months? ☐ Yes ☐ No If yes, where? _____

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct any treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physicians.
- Obtain outcome measures for research purposes.

I have been informed by you of your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such ***Notice of Privacy Practices*** prior to signing this consent. I understand that this organization has the *right* to change its ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the ***Notice of Privacy Practices***.

I understand that I may request *in writing* that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operations. I also understand you are *not required* to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent *in writing* at *any time*, *except* to the extent that you have taken action relying on this consent.

Patient Name: _____

Relationship: _____

Signature: _____

Date:_____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION FROM DESIGNATED RECORD SET PURSUANT TO HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) AND FEDERAL REGULATION 45 CFR 164.508

Patient's Name: _____

Address: _____

Date of Birth: _____ Social Security Number: _____

Pursuant to HIPAA and 45 CFR 164.508, I, _____, hereby Authorize and Request _____ and its Agents, Employees and/or Sub-Contractors to disclose the following specific Protected Health Information from my Designed Records sent to _____ and its Agents, Employees and/or Subcontractors.

DESCRIPTION OF INFORMATION TO BE DISCLOSED

I hereby Authorize and Request the following specifics Protected Health Information be disclosed to _____, and its Agents, Employees and/or Subcontractors for Dates of Service beginning on _____ through _____.

___ ALL RECORDS

___ OTHER _____

PURPOSE OF REQUESTED USE

This Authorization is made "at the request of the individual." Pursuant to 45 CFR 164.508 (6)(c)(iv), this statement satisfied the "description of each purpose" requirement.

EXPIRATION OF AUTHORIZATION

This Authorization will expire on the date that you receive notice that my attorney no longer represents me, or One Hundred Eighty (180) days from today's date of _____, or whichever is sooner.

HIPAA NOTICE REQUIREMENTS

I understand that I have the right to revoke this Authorization in writing, except to the extent the Healthcare Provider has already taken action on it. I also understand that my medical treatment, payments, health insurance payments may not be conditioned on me signing this Authorization. I further understand that once my medical information and medical records are disclosed to my attorney and/or legal counsel, it may be subject to re-disclosure by said attorney or counsel and will not be protected pursuant to the same privacy regulations.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

WITNESS SIGNATURE DATE

Caterra Health Systems

AUTHORIZATION

Authorization to Release Information: By signing this authorization you are deemed to understand and permit Caterra Health Systems, LLC, or any of its affiliates to release any information stated herein and any private or HIPPA protected information any of the aforesaid entities deem necessary to a third party investigator in the event that one is retained to contact you and/or to your attorney.

Medicare: I hereby request that payment of authorized medical benefits be made to Caterra Health Systems, LLC for any services furnished to me by any of those medical facilities. I authorize the release of any medical information about me, from any holder of said information, to the Health Care Financing Administration and its agents. That release encompasses any information needed to determine benefits payable for related services provided by Caterra Health Systems, LLC.

Commercial Insurance: I hereby authorize Caterra Health Systems, LLC to submit claims to my insurance carrier or its intermediaries for any and all covered services rendered by either facility and **DIRECT MY INSRUANCE CARRIER AND ITS INTERMEDIARIES TO ISSUE PAYMENT BY CHECK DIRECTLY TO THE CHARGING FACILITY.**

Pursuing Basic Reparation Benefits: I hereby authorize Caterra Health Systems, LLC or any of its affiliates, to pursue any and all basic reparation benefits I am entitled to pursuant to KRS 304.39-030, *et. seq.*

Filing an Insurance Consumer Complaint: I hereby authorize Caterra Health Systems, LLC or any of its affiliates, to file a Consumer Complaint against the insurance company providing my no-fault benefits with the Kentucky Department of Insurance for non-payment and/or delayed payment of any medical bills I incur.

Authorization to Release PIP Log: I hereby authorize Caterra Health Systems, LLC, or any of its affiliates to obtain my PIP log showing all payments made by my reparation obligor under KRS 304.29.

I understand that I am wholly financially responsible for any balance not covered by my insurance carrier(s).

Patient Name:_____

Signature: _____ Date: _____

Caterra Health Systems

PAYMENT AGREEMENT AND LIEN AUTHORIZATION

I, _____, do hereby authorize Caterra Health Systems, LLC to furnish you, my attorney, with a full report of my examination, diagnosis, treatment, prognosis, and complete patient file, in regards to the incident which forms the basis and need for my medical treatment with Caterra Health Systems, LLC.

I hereby authorize and direct you, my attorney, to pay directly to such sums as may be due and owing, Caterra Health Systems, LLC for medical services rendered to me by reasons of the aforesaid incident and/or for any medical treatment and services provided to me by Caterra Health Systems, LLC. I authorize you to withhold such sums from any settlement, judgment, and/or verdict as may be necessary to satisfy any outstanding amount owed to Caterra Health Systems, LLC for my medical treatment and care with its facility. I hereby further authorize a lien on my case to Caterra Health Systems, LLC against any and all proceeds of any settlement, judgment, and/or verdict in which may be obtained by you, my attorney, on my behalf which in any way relates to the injuries for which I have been treated at the above-named facility or in connection therewith.

I fully understand and agree that I am directly and wholly responsible to Caterra Health Systems, LLC for all medical bills submitted for services rendered to me and that this agreement is binding and made solely with Caterra Health Systems, LLC for additional protection and consideration of their awaiting payment. I further understand that such payment is not contingent upon any settlement, judgment, and/or verdict by which I may eventually recover said fee and that my obligation for payment to Caterra Health Systems, LLC is continuing until any outstanding charges owed to Caterra Health Systems, LLC are satisfied in full.

Patient Signature: _____ Date: _____

The undersigned, being the attorney of record for the above patient, does hereby agree to observe all the terms of the above agreement and further agrees to withhold such sums from any settlement, judgment, and/or verdict as may be necessary to satisfy any outstanding payment obligation of the above patient to Caterra Health Systems, LLC.

Attorney Signature: _____ Date: _____

Caterra Health Systems

DIRECTION OF PIP BENEFITS

I _____, hereby request, in writing, that payment be made directly to Caterra Health Systems, pursuant to KRS 304.39-241. Please provide immediate payment to Caterra Health Systems, pursuant to KRS 304.39-241, upon your receipt of each individual bill and expense as it is incurred. I understand that I have the right to direct payment pursuant to KRS 304.39-241, and affirm that this writing is to serve as my request to direct payment of my PIP benefits to Caterra Health Systems.

Any provision of this writing which is prohibited or unenforceable in any jurisdiction shall, as to such jurisdiction, be ineffective to the extent of such prohibition or unenforceability without invalidating the remaining portions hereof or affecting the validity or enforceability of such provision in any other jurisdiction.

This writing constitutes the entire and exclusive understanding and intent of the undersigned with respect to the subject matter hereof and supersedes and cancels all previous registrations, agreements, commitments, writings, and writings in respect thereof. This writing also acts to supersede and cancel all previous requests to direct payment of PIP benefits pursuant to KRS 304.39-241.

This Agreement shall be construed in accordance with the laws of the Commonwealth of Kentucky.

Signature: _____ Date: _____

SSM Diagnostics, LLC

PAYMENT AGREEMENT AND LIEN AUTHORIZATION

I, _____, do hereby authorize SSM Diagnostics, LLC to furnish you, my attorney, with a full report of my examination, diagnosis, treatment, prognosis, and complete patient file, in regards to the incident which forms the basis and need for my medical treatment with SSM Diagnostics, LLC.

I hereby authorize and direct you, my attorney, to pay directly to such sums as may be due and owing, SSM Diagnostics, LLC for medical services rendered to me by reasons of the aforesaid incident and/or for any medical treatment and services provided to me by SSM Diagnostics, LLC. I authorize you to withhold such sums from any settlement, judgment, and/or verdict as may be necessary to satisfy any outstanding amount owed to SSM Diagnostics, LLC for my medical treatment and care with its facility. I hereby further authorize a lien on my case to SSM Diagnostics, LLC against any and all proceeds of any settlement, judgment, and/or verdict in which may be obtained by you, my attorney, on my behalf which in any way relates to the injuries for which I have been treated at the above-named facility or in connection therewith.

I fully understand and agree that I am directly and wholly responsible to SSM Diagnostics, LLC for all medical bills submitted for services rendered to me and that this agreement is binding and made solely with SSM Diagnostics, LLC for additional protection and consideration of their awaiting payment. I further understand that such payment is not contingent upon any settlement, judgment, and/or verdict by which I may eventually recover said fee and that my obligation for payment to SSM Diagnostics, LLC is continuing until any outstanding charges owed to SSM Diagnostics, LLC are satisfied in full.

Patient Signature: _____ Date: _____

The undersigned, being the attorney of record for the above patient, does hereby agree to observe all the terms of the above agreement and further agrees to withhold such sums from any settlement, judgment, and/or verdict as may be necessary to satisfy any outstanding payment obligation of the above patient to SSM Diagnostics, LLC.

Attorney Signature: _____ Date: _____