Health & Healing Family Chiropractic

WORKERS' COMPENSATION HISTORY

Name_____Date of Birth_____Date_____
Occupation_____Employer_____
Employer's Address_____
Work Phone_____Supervisor's Name & Position_____
Work Insurance Company_____Claim Number_____
Have you retained an attorney?_____Name_____Phone #_____

INJURY DESCRIPTION
Date present injury occurred_____Time_____Overtime_____
Who saw the accident?_____Title_____
To whom did you report the accident?_____Title_____
How did the injury occur?_____
_____
_____
Symptoms_____
Medical care given_____
By whom_____Degree_____Title_____
If working a machine, give description_____
_____
Do you use foot/hand levers?_____Do you work overhead?_____
Do you have to reach?_____Where?_____
Do you lift or pick up?_____How much?_____How often?_____
Lifting form where to where?_____
On the job do you push or pull?_____Describe_____
_____

OFFICE WORK (If your injury has occurred from office work only, fill out the following)
Sit Walk Stand Stoop Hold Carry Other_____
Give a percentage if applicable_____Do you operate a machine?_____
If yes, which one (s)?_____
If you work at a desk, give specific jobs (computer, phones, etc.)_____
_____
Do you carry anything or pick anything up?_____What?_____

Give job description for jobs held in the last ten years
1._____
2._____
3._____
4._____
5._____
Was a pre-employment exam performed or required?_____
Date_____Doctor_____Location_____
Have you ever applied for worker's compensation benefits before?_____
Reason_____
Was there a loss of time?_____From_____To_____
State the degree of recovery_____
Did you retain legal counsel for these injuries?_____

PRESENT WORK HISTORY

What is the classification of your normal job?_____
Were you performing your normal duties?_____What shift?_____
How long have you been at your current position?_____
Have you lost any work time form this present injury?_____
Average work week_____Hours_____Days_____

JOB CONDTIONS

Type of building_____
Type of floor: Rough Smooth Wood Concrete Steel Other_____
Type of lighting: Fluorescent Overhead On Machine None Other_____
Are you tired when you go home at night?_____
Do you have any outside jobs?_____Describe_____
Do you participate in any company programs (stretching, exercise, sports, etc.)_____
_____
Type of shop: Union_____Non-Union_____
Number of staff work at building_____Number of staff on your shift_____
Do you like your job?_____Would you like to return to your job?_____
What changes would you like to make in your job?_____
_____

_____ _____
Patient Signature Date

FINANCIAL STATEMENT

Dear Patient:

Automobile Accidents and Worker's Compensation: For automobile, under Minnesota no-fault law and if/when your auto insurance carrier establishes liability, they will pay 100% of covered services directly to your practitioner's office. For all insurances in this category, you are responsible for paying for any non-covered services, supplies or supplements which are due at the time the charges are incurred. In the event that your insurance denies liability or your benefits end, payment for services rendered becomes your responsibility, if you provide us with a copy of the denial letter and if you have other health insurance coverage, we will submit your claims to your health insurance company. Coverage would then fall under the guidelines of the type of insurance you have.

I have read, understand and agree to abide by the information stated above as it applies to my coverage. If special payment arrangements are necessary, they would have to make through the clinics' billing manager.

Printed Name_____

Signature_____Date_____

1883 Station Parkway NW ° Andover, MN 55304 ° t:763.323.0061 ° f:763.754.9756

DOCTOR'S LIEN
AND INSTRUCTIONS TO COUNSEL

I, the undersigned, understand that all past, present and future bills incurred at the Doctor/Clinic noted below, are my responsibility for payment. I hereby ratify my agreement to pay all bills incurred during my health care at this Clinic

In consideration for the below named Doctor/Clinic having agreed to treat me without payment at the time of service and enabling me to obtain treatment for my accident/injury/illness, without financial hardship, I give you a lien on any settlement, claim, judgment. Verdict or result of said accident/injury/illness and I agree to irrevocably instruct my attorney to pay you in full from any proceeds of settlement, claim or judgment related to this accident/injury/illness.

I also understand that if the settlement does not cover my entire bill at this Clinic, I am still responsible for the remainder and the payment by me of this bill is not contingent on any settlement, claim or judgment with I may eventually recover.

Furthermore, in consideration for the below named Doctor/Clinic refraining from attempting to collect immediate payment for services rendered for my accident/injury/illness, I do hereby waive and toll any applicable statute of limitations on the collection of my account until I notify the Doctor/Clinic of the conclusion of my efforts to obtain a settlement or judgment through the assistance of my attorney and for a period of three (3) months thereafter.

Karrie Lehn, DC / Kerri Norring, DC
Health & Healing Family Chiropractic
1883 Station Parkway NW
Andover, MN 55304
T (763) 323-0061 **F** (763) 754-9756

Doctor/Clinic Name and Address

_____
Patient Name (Please Print)

_____
Patient Signature

_____
Date

* * * * * *

INTRUCTIONS TO COUNSEL

I do hereby irrevocably instruct you, my Attorney, named below, to pay Doctor/Clinic named above in full for services to me for my accident/injury/illness from any proceeds of settlement, claim or judgment regarding said accident/injury/illness. You are to pay the Doctor/Clinic prior to distributing any proceeds to me and I instruct you not to attempt to reduce by means of negotiation my doctor's bill for the services that have been provided to me for the accident/injury/illness which I have agreed to pay in full.

_____
Firm Name

_____
Attorney Name

_____
Patient Signature

_____
Date

* * * * * *

ATTORNEY'S ACCEPTANCE OF LIEN

Being the attorney of record or authorized representative, I acknowledge receipt of my client's instructions to Counsel and Lien and agree to honor the same.

_____
Attorney Signature

_____
Date