How did you hear about **WOL+MED**? Who Referred You?

Please tell us why you chose **WOL+MED** for your work or auto injury. Who can we thank for your referral?

☐ I saw the **sign** on the building / next to the highway.

☐ I saw a **newspaper** ad in the Denton Record Chronicle.

☐ The **ER** sent me here.

____ Denton Regional Medical Center
____ Denton Presbyterian
____ Lewisville Medical Center
____ Other ____________________________

☐ I saw an ad in the **Yellow Pages**.

____ Yellow Book, Denton
____ Yellow Book in another town (which town?)___________________
____ AT&T, Gainesville
____ Verizon (IDEARC), Denton
____ Verizon (IDEARC), Lewisville
____ My Lonestar Pages, Denton
____ My Lonestar Pages, Cooke County
____ Other (Please Specify)______________________

☐ A **Friend** Referred me (Please tell us who)___________________________

☐ A **Family** Member Referred me (Please tell us who)__________________________

☐ A **Co-Worker** Referred me (Please tell us who)___________________________

☐ A **Doctor** Referred me (Please Specify which Doctor)_________________________

☐ An **Attorney** Referred me (Please specify which Attorney)______________________

☐ My **Employer** Referred me (Please specify which Employer)_____________________

☐ I saw the web site (**www.wolmed.com**) and decided to come here.

☐ I searched the internet and found **WOL+MED**.
(Which search engine did you use?)

____ Google
____ Yahoo
____ MSN
____ AOL
____ Superpages.com (from Verizon)
____ Yellow Book.com
____ Other (Please Specify)_______________

☐ I was already a patient here.

☐ Other (Please Specify)____

X X

PATIENT INFORMATION FORM

(Please **PRINT** legibly and fill in **COMPLETELY**.) Date_______/_______/_______

	(please give Driver's License to receptionist to copy)
Last Name________________	Driver's License ________________
First Name________________ M.I.______	Email address ________________
Address ________________	Home phone (________)________-________
City ________ State______ Zip________	Work phone (________)________-________
Employer/School________________	Cell # (____) ____-______ Fax # (____) ____-______.
Employer Address________________	Date of Birth____________Age________
City________State________Zip________	Social Security #________-______-________
Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Person Responsible for payment ☐ Self	Occupation________________
or ________________	Student ☐ Yes ☐ No

PLEASE FILL IN COMPLETELY

Spouse's or Significant Other's Name			
Spouse's or Significant Other's Employer	Occupation (check if student)	How Long Employed	Bus. Phone
Spouse's or Significant Other's Employer's Address	City and State	Zip	Bus. Phone
Spouse's or Significant Other's Address (if different)	City and State	Zip	Home Phone
Has any member of your family been here before? (Names and ages)			
Mother's Name	Street Address, City, State, and Zip		Home Phone
Mother's Employer and Location		Occupation	Bus. Phone
Father's Name	Street Address, City, State, and Zip		Home Phone
Father's Employer and Location		Occupation	Bus. Phone
In case of emergency please notify: (other than parents, spouse, or anyone living at your residence)			Home Phone
Relationship	Street Address, City, State, and Zip		Bus. Phone
Your Hobbies:		Have you been here before? Y N What year? 19___	

HOW DID YOU HEAR ABOUT US?

Saw sign
- ☐ on building/parking lot
- ☐ bowling alley

☐ newspaper
☐ emergency room
- ☐ DRMC ☐ DCH

☐ Yellow Book Denton

☐ Gainesville - SBC
☐ Verizon - Denton
☐ Verizon – Area Wide
☐ Verizon – Gainesville Complimentary

Internet/Web pages
☐ Google, (www.adwords.com)
☐ Yahoo,
☐ MSN
☐ Direct Internet Access
☐ Web site (www.wolmed.com)
☐ (www.superpages.com)

☐ friend (name)________________
☐ relative (name)________________
☐ doctor (name) ________________
☐ attorney (name) ________________
☐ employer (name) ________________
☐ other (describe) ________________

PLEASE TURN OVER AND COMPLETE OTHER SIDE

PLEASE FILL IN COMPLETELY. PLEASE PRINT.

INSURANCE INFORMATION

If insurance information is incomplete, if deductible is not met, or if we cannot confirm insurance coverage, payment will be expected and due at time services are rendered. If your insurance company requires special forms to be filled out, it is your responsibility to complete all of the patient information and deliver the forms to us at the time services are rendered.

If you want us to bill your insurance, please...

(1) let us photocopy your current insurance card and driver's license.

(2) give us your insurance claim form supplied by your insurance company (with the patient portion filled out and signed in both places requested).

A. I assign the professional or medical expense benefit allowable and otherwise payable to me under my current insurance policy to **WOL + MED** as payment toward total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original.

B. **I authorize the release of any information pertinent to my case to any insurance company, adjuster, my attorney, my employer (employer only for work related injuries), my managers, or other doctors involved in this case.**

C. I authorize release of all medical records from all other medical providers to **WOL + MED.**
FAX Medical Records to ☐ **775-599-3899 Denton**
☐ **972-572-9448 Dallas**

D. **I understand that if I do not wish to file on my insurance or if any insurance (or any other third party) does not fully cover the charges incurred, I am fully responsible for paying the balance of my account.**

E. To: Texas Workers Comp Commission or any out of state Workers Compensation Commission.
Please release any and all information regarding my case to Wol+Med Medical, P.A.

Date _____/_____/____

____
Signature of policy holder

____
Signature of claimant if other than policy holder

(For Office Use Only: When requesting medical records fax this form plus the patient information form)

MVA/PI Insurance

Patient's name______________________________

A) PIP- Personal Injury Protection Insurance

This is medical coverage you have with your auto insurance. Filing a PIP claim does **not** increase your insurance premium.

Insurance Company ______________________________

Policy # ______________________________

Claim # ______________________________

Adjuster's name ______________________________

Adjuster's phone # ______________________________

PIP Coverage: Yes ___ or No ____

B) 3rd Party Insurance-Insurance carrier of person at fault

Insurance Company ______________________________

Claim # ______________________________

Adjuster's name ______________________________

Adjuster's phone # ______________________________

Attorney Filing 3rd Party: Yes ___ or No ____

C) Attorney

Attorney's Name ______________________________

Phone Number ______________________________

D) Health Insurance-Please give the front desk a copy of your insurance card to have on file.

_____ NO Health Insurance

E) WE NEED A COPY OF THE DECLARATION PAGE OF YOUR AUTO POLICY
F) WE NEED A COPY OF THE POLICE REPORT

MOTOR VEHICLE ACCIDENT AND PERSONAL INJURY – NEW INJURY FORM

PATIENT INFORMATION Please print. Give complete answers to all questions.

Last Name	First	Middle	Today's Date / /	Date of Accident / /

LIABILITY
Did the other vehicle strike you from the ☐front? ☐back? ☐left side? ☐right side?
Give all the details of how your accident occurred.______________________________

Were the police notified? ☐Yes ☐No (Please give us a copy of police report.)
Did anyone get a ticket? ☐Yes ☐No Who?______________________________
Were you partially at fault? ☐Yes ☐No Is there a disagreement whose fault the accident was? ☐Yes ☐No
Whose fault was the accident?______________________________

INSURANCE (Please give us a copy of your group health and auto insurance.)
Were you the driver? ☐Yes ☐No A passenger? ☐Yes ☐No A pedestrian (on foot)? ☐Yes ☐No
Who owns the car you were in? ☐ Self or Name______________________________
Who was driving the car you were in? ☐ Self or Name______________________________

Do you have any of the following insurance?	Yes	No	Don't Know	Limit
a. Auto insurance?	Y	N	?	$
b. Personal injury protection for the vehicle you were in?	Y	N	?	$
c. Personal injury protection for any other vehicle?	Y	N	?	$
d. Uninsured motorist insurance?	Y	N	?	$
e. Liability insurance?	Y	N	?	$ per person $ per accident
If you were a passenger, do the following have insurance?	Y	N	?	
a. Driver has PIP insurance.	Y	N	?	$ person
b. Driver has liability insurance.	Y	N	?	$ person
Does anyone else in your family/household have an insured vehicle?	Y	N	?	
Have you filed for your PIP insurance?	Y	N	?	
Does the driver at fault (of the other vehicle) have liability insurance?	Y	N	?	
Do you have health insurance?	Y	N	☐Group health ☐PPO ☐HMO	
Were you "on the job" when the accident happened?	Y	N		
If you were on the job, have you filed for Worker's Comp insurance?	Y	N		
Was the person who hit you "on the job?"	Y	N		

Were you hit by a "private" vehicle? ☐Yes ☐No a "company" vehicle? ☐Yes ☐No an 18 wheeler? ☐Yes ☐No

Make and model of vehicle you were driving or riding in

Make and model of vehicle that hit your car Year

How many other people were injured in your vehicle? ☐Names are: Year

Do the other injured people need medical care at our office? ☐Yes ☐No

Full name and address of your attorney Phone

How much damage was done? (Please give us a picture of your car.)						Estimated cost to repair
a. to your vehicle?	☐ scratched	☐ slight	☐ medium	☐ severe	☐ totalled	
b. to other vehicle?	☐ scratched	☐ slight	☐ medium	☐ severe	☐ totalled	your car $__________

HEALTH SURVEY

Check √ any **SERIOUS** problems you have now or have had in the past. Check **"NOW"** if you have problem NOW. Check **"PAST"** if you had problem in the PAST. Check **"NEVER"** if you have NEVER HAD this problem.

MEDICAL

In what exact area did you feel pain immediately after the accident?
What x-rays did you receive? ☐skull ☐ neck ☐ upper back ☐ lower back ☐ other (describe)
Were you ☐ in front seat? ☐ in back seat? ☐ using seat belts?
If you were unconscious, what was the approximate length of time?
If you consulted another doctor, give full name and address:
What was the doctor's diagnosis?
What treatment, if any, did that doctor provide?
How many treatments have you had already?
If you had injuries to the same place before the accident, please describe them:
Before this injury were you able to work on an equal basis with others your age? ☐Yes ☐No
Has this accident restricted your work performance? ☐Yes ☐No
Since this injury, are your symptoms: ☐The same? ☐ Better? ☐ Worse?
Did a friend or one of our patients refer you to us? What is their name?

Kidney/Bladder	now	past	never
Can't control bladder			
Bladder trouble			
Excessive urination			
Scanty urination			
Painful urination			
Discolored urine			
Have trouble urinating			

FEMALE

Are you pregnant? ___ Yes ___ No
If you are pregnant, we cannot do x-rays.

Gastrointestinal	now	past	never		now	past	never		now	past	never
Difficult chewing				Vomiting food				Abdominal pain			
Nausea				Vomiting blood				Can't control bowels			

Nervous System	now	past	never		now	past	never		now	past	never
Numbness				Loss of feeling				Muscle jerking			
Numbness, tingling, or weakness of legs or feet				Paralysis				Convulsions			
				Dizziness				Forgetfulness			
Numbness, tingling, or weakness of arms or hands				Fainting				Confusion			
				Headaches				Depression			

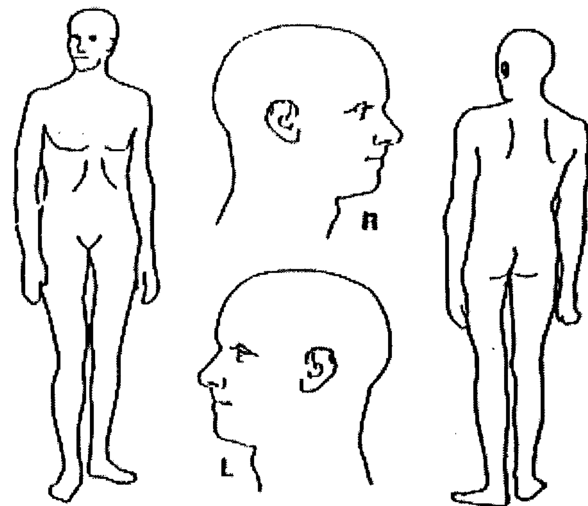
Chest	now	past	never		now	past	never		now	past	never
Chest pain				Difficult breathing							

Eye, Ear, Nose, & Throat	now	past	never		now	past	never		now	past	never
Vision problems				Ear discharge				Sore gums			
Ear pain				Nose pain				Problems with teeth			
Ear noises				Nose bleeding				Sore mouth			
Hearing loss											

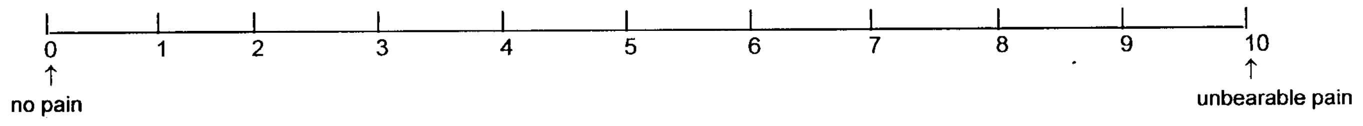
Bones, Joints, & Muscles	now	past	never
Low back pain			
Upper back pain			
Pain between shoulders			
Neck pain			
Shoulder pain			
Arm pain			
Knee pain			
Leg pain			
Swollen joints			
Painful joints			
Stiff joints			
Sore muscles			
Weak muscles			
Walking problems			
Need help walking			
Ruptures			
Broken bones			

Mark areas of pain resulting from this accident on figures.

Aching	Numbness	Pins & Needles	Burning	Stabbing
XXX	000	===	▲▲▲	///



Mark an "X" on the following scale to show how bad your pain is:



Patient's signature________________________________ Date____________
(If a minor, parent's or guardian's signature)

COMPLETE HISTORY FORM (Please try to **answer** all **questions** on **both sides**. This information will **be treated as confidential**.)

Name____ Today's Date______/______/______

Date of birth______/______/______ Age______

PAST HEALTH HISTORY

Month & year of last yearly physical_____/______ ☐ Never

Have you ever had any of the following conditions? Check **"NOW"** if you have problem NOW. Check **"PAST"** if you had problem in the PAST. Check **"NEVER"** if you have NEVER HAD this problem.

	Now	Past	Never		Now	Past	Never		Now	Past	Never
Anemia/blood disease				Tuberculosis				Kidney disease			
Thyroid trouble				Pneumonia				Back pain			
Diabetes				Stomach ulcers				Epileptic seizures			
Rheumatic fever				Liver disease				Alcohol or drugs			
High blood pressure				Jaundice				Auto injury			
Heart problems				Cancer				Work injury			

List medications you take regularly?____

What drugs are you allergic to? ____

Have you had all your "shots" (immunizations)? ☐Yes ☐No

Name and address of previous family doctor.____

Do you want to be notified when your yearly physical & blood tests are due? ☐Yes ☐No

Please list any SERIOUS illnesses, hospitalizations, cancers, or surgeries you have had.

Date	Illness or Operation	Doctor and/or Hospital	Mark X and enter Date if you have had.
			☐19___ X-rays of ______________
			☐ 19___ Scan of ______________
			☐ 19___ Colon tests
			☐ 19___ Breast x-rays
			☐ 19___ Heart tests
			☐ 19___ Pneumonia shot
			☐ 19___ Yearly physical
			☐ 19___ Yearly blood tests

FAMILY HEALTH ("Blood" relations only) Check "✓" if adopted. ☐

Relative	Names	Age	Sex	Health Problems	If dead, cause of death	Age	Has any relation had	Yes	No
Father			M				Tuberculosis		
Mother			F				Heart disease		
Brothers & Sisters							High blood pressure		
							Alcoholism		
							Kidney disease		
							Diabetes		
							Strokes		
Children							Epilepsy		
							Nervous breakdown		
							Allergies or Asthma		
							Anemia		
							Cancer		

Please turn page! Please fill out the back of this sheet!

Check "✓" any **SERIOUS** problems you have now or have had in the past. Check "**NOW**" if you have problem NOW.
Check "**PAST**" if you had problem in the PAST. Check "**NEVER**" if you have NEVER HAD this problem.

	now	past	never		now	past	never		now	past	never
Always Tired				Chills				Always Hungry			
Need Complete Yearly Physical?				Very Thirsty				Difficulty Sleeping			
Need Yearly Blood Tests?				Night Sweats				Bleeding Tendency			
Loss of Appetite				Warm "Blooded"				Growths, Tumors, Lumps			
Loss of Weight				Cold "Blooded"				Number of Alcoholic Drinks/Day			
Want Weight Loss Program?				Skin Trouble				Use/used Marijuana/Drugs			
Fever				Fainting or Dizziness				Need AIDS Test?			

HEAD & NECK

	now	past	never		now	past	never		now	past	never
Allergies				Ever had Allergy Tests?				Itchy Eyes			
Headaches				Need Allergy Tests?				Frequent Colds			
Eye Trouble				Nasal Congestion				Sore Throat			
Hearing Difficulty				Nose Bleeds				Lumps in Neck			
Earaches				Congested or Runny Nose				Neck Pain			
Sinus Trouble				Sore Tongue				Sneezing Spells			

RESPIRATORY

	now	past	never		now	past	never		now	past	never
Cough				Wheezing				Cigarette smoking			
Cough up phlegm				Shortness of breath				Number per day			
Cough up blood				Date of last TB test				Date of last chest x-ray			

CARDIOVASCULAR

	now	past	never		now	past	never		now	past	never
Shortness of breath walking				Racing/skipping heart beat				Pains in Legs Feet (circle)			
Shortness of breath at night				Heart murmur				Poor circulation in legs			
Chest pains or pressure				Date last electrocardiogram				Cold feet, leg cramps			
High blood pressure				Swelling of ankles				Phlebitis (inflammation of veins)			

DIGESTIVE

	now	past	never		now	past	never		now	past	never
Difficulty swallowing				Abdominal pain				Bloody bowel movements			
Heartburn				Gas & Bloating				Black bowel movements			
Nausea				Constipation				Do you take laxatives?			
Vomiting				Diarrhea				Any foods cause indigestion?			
Vomiting blood				Belching				Anal tags or growths			
Lump in throat				Blood on toilet paper				Hemorrhoids			

URINARY

	now	past	never		now	past	never		now	past	never
Need to urinate often				Genital growths or warts				Getting up at night to urinate			
Painful urination				Wetting pants or bed				Weak urine stream			
Blood in urine				Difficulty starting urine				Have to run to the bathroom			

BONE AND JOINTS

	now	past	never		now	past	never		now	past	never
Pain, stiffness, joint swelling				Have you had broken bones?				Back pain Neck pain (circle)			
Loss of joint movement				Foot trouble (warts or corns)				Do you need physical therapy?			

NERVOUS SYSTEM

	now	past	never		now	past	never		now	past	never
Forgetfulness				Abnormal sensations, numbness				Difficulty walking			
Nervousness				Loss of balance				Tremors, shaking			
Depression				Clumsiness				Muscle weakness			
Frequent thoughts of suicide				Spells of any kind				Sexual difficulties of any type			
Poor concentration				Worry too much				Hot flashes			
Crying spells				Family marital problems				Irritable, feel like screaming			

SKIN

	now	past	never		now	past	never		now	past	never
Warts hands feet other				Tatoos				Ingrown toe nails			
Moles				Rashes				Corns on feet			
Skin growths				Spots or veins on face				Veins on legs			

WOMEN ONLY

	now	past	never		now	past	never			
Irregular menstruation				Have you passed menopause?				Number of pregnancies		
Painful menstruation				Abnormal discharge or itching				Number of miscarriages		
Very heavy periods				Do you take birth control pills?				Date of last menstrual period		
Bleeding between periods				Any trouble with breasts				Date of last yearly pap smear		
Are you pregnant?				Hysterectomy				Need wrinkle laser surgery	Yes	No

What is your main problem today?____________________

What other problems do you have not listed above?____________________

Doctor's signature____________________

WOL ╬ MED FINANCIAL POLICY

X X

A. NO INSURANCE

If you do not have health insurance, payment by cash, check, or credit card is required at the time of service.

B. BILLING HEALTH INSURANCE

1. If you have health insurance, we will file the claims for you if:
   a. you allow us to photocopy your insurance card and driver's license.
   b. you have completed and signed both sides of the patient information form

2. You will need to pay your copay or coinsurance at the time of services.

3. If your insurance company reduces our charges, you are responsible for the remainder after insurance payment is credited to your account. You are also responsible for payment of all "non-covered" services as indicated by your insurance company. If your insurance pays only a part of the bill, you are responsible for the remainder.

C. MEDICARE

1. We are a Medicare participating physician. We accept assignment on Medicare claims filed.
2. You are responsible for your annual deductible (currently $110.00). You have to pay the first $110.00 of allowable charges for the current year.

3. Medicare will pay our office 80% of the "allowable" charge (An "allowable charge" is the charge set by Medicare). By law, Medicare rules that we must collect 20% coinsurance from our Medicare patients.

4. Since Medicare pays 100% of the allowable charges on laboratory work, all blood tests are "free" to Medicare patients.

D. STATEMENTS

1. You will receive a statement once a month on outstanding balances. Payment is due within two weeks after receiving a statement. **It is your responsibility to notify us if your address changes**.

E. DELINQUENT ACCOUNTS

We do turn delinquent accounts over to an independent collection agency. We want to work with you to avoid this last effort to clear your account, so please notify our office of any changes of address or employment. Your best protection is to pay your copay and to pay for non-covered services at each visit so that you are never faced with an accumulation of multiple visits.

F. WORKER'S COMPENSATION

1. There is no charge to you for a verified worker's compensation injury.
2. You must bring us a photocopy of a "First Report of Injury" signed by your supervisor or have your supervisor telephone us to verify your coverage.
3. If your injury is not covered by worker's compensation, you will be responsible for payment for services.

If you have any questions, problems, or changes, please notify us. We are here to help you.
I agree to the above financial policy.
Date ______/______/______ ________________________________

Signature

WOL+MED BACK AND NECK PAIN CENTER

Advance Directive:

Wol+Med Back and Neck Pain Center recognizes each individual's right to choose medical intervention. This document is to serve as your written will and intent for receiving medical intervention including CPR and appropriate resuscitation in the event of a medical emergency.

While in a cognizant and coherent mental state, I ________________________________
Execute my right to choose or deny medical intervention/resuscitation by placing a mark in one of the following:

________Yes, while in Wol+Med Back and Neck Pain Center, I choose to receive resuscitation and medical intervention in the event of a medical emergency. I fully understand that this intervention will potentially keep me alive with disregard to quality of life.

________No, while in Wol+Med Back and Neck Pain Center, I choose not to receive resuscitation and medical intervention including CPR in the event of a medical emergency. I fully understand the medical consequences resulting from this decision including regards to quality of life and ultimately death.

I have executed my rights and intent for the above.

___________________________ ___________________
Signature Date

___________________________ ___________________
Witness Date

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____
Signature of Patient or Personal Representative

____
Date

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority

PARTIAL ASSIGNMENT OF CAUSE OF ACTION, ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN AND TREATMENT AGREEMENT

(Herein, Agreement; Rev. 02-17-04)

Consideration. In order to facilitate the ability of the Office to collect its Charges directly from various Payers and thereby to enhance the patient-provider relationship, I, the undersigned, as consideration for the Office=s services, agree to the following and direct all Payers as follows:

Partial Assignment of the Cause of Action, Assignment of Proceeds, and Contractual Lien. I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to the Office, as well as any and all causes of action that I might have now or in the future against any Payer to the extent of my Charges, the right to prosecute such causes of action either in my name or in the Office=s name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. I further assign my right to receive any Proceeds from any Payer to the Office and further grant a contractual lien to the Office with respect to my Charges. I understand that these assignments of rights and contractual lien may effectuate, automatically or otherwise, a secured interest under the applicable Uniform Commercial Code. I intend for this Agreement to effectuate such a lien and hereby authorize the Office to file the form(s) normally filed with the secretary of state or other governmental agency in order to perfect such lien. Except as provided herein, nothing in this Agreement shall be construed as an election or waiver by the Office to a secured interest under any other statutory lien law. Consistent with these rights, I hereby direct any and all Payers, to pay the Proceeds directly and immediately to, and exclusively in the name of, the Office in the amount of my Charges.

Other Terms. I understand that I remain personally responsible for my Charges. Consistent with law or contract, I agree to pay the full amount of my Charges to the Office upon its demand. Unless mutually agreed to in writing, the receipt and processing of partial payments by the Office shall not constitute a waiver of the Office=s right to receive payment-in-full upon demand and shall not constitute an accord and satisfaction of my Charges, irrespective of any restrictions indicated on any payments. I understand that at any time, I can request a copy of my total Charges. I hereby waive any statute of limitations which may apply to the collection of my Charges.

In the event that I retain one or more attorneys to assist me in collecting any Proceeds, I direct each attorney to issue an irrevocable letter of protection to the Office regarding my Charges. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office.

I authorize and direct the Office to submit my Charges to any and all Payers including, without limit, my health benefit plan. I understand, however, that in the event that my Charges are submitted to more than one Payer, I hereby authorize and direct the Office to apply any Proceeds received from one Payer to any reductions, write-offs, or discounts, issued by another.

I authorize the Office to endorse or sign my name on any and all checks listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

This Agreement shall not be modified or revoked without the mutual written consent of the Office and myself. I hereby revoke the terms of any previously signed documents to the extent those terms conflict with the terms of this Agreement.

This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-conveniens.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Definitions. For the purposes of this Agreement, the following terms shall have the following meaning: AOffice@ shall refer to: Edward F. Wolski, M.D. P.A. dba Wol+Med located at 2436 IH-35 E. South #336, Denton, TX 76205; APayer@ shall refer to, without limit, any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at-fault party, tortsfeasor, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds to me, either now or in the future, for any reason; AProceeds@ shall include, without limit, the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare, Medicaid, workers= compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice; ACharges@ shall include, without limit, the full fees for the Office=s services (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, depositions, and testimony), any Collection Costs incurred by the Office, 18% interest on outstanding Charges, and any other charges incurred by me at the Office; ACollection Costs@ shall include, without limit, any pre- and post judgment court costs, filing fees, service of process charges, attorneys fees, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Patient Name (please print): ______________________________

Patient Signature: ______________________________ Date: ___/___/___

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): ______________________________

Parent/Guardian Signature: ______________________________ Date: ___/___/___

Notice of Our Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
Effective: 4/14/2003 (must be on or after the date of first printing or publication)

Under Federal Law, how might your protected health information need to be used/ disclosed by our office for treatment, payment, or health care operation purposes?

Generally, your protected information may be used or disclosed by our clinic for treatment, payment, or specific health care operations. These three words or phrases are defined by Federal Law, 45 CFR s 164.501 and other regulations as follows:

Treatment. *Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.*

Payment. *The activities undertaken by us to obtain or provide reimbursement for the provision of health care.* Such activities include without limit determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims; billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing; and review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges.

Other Health Care Operations. 45 CFR s 164.501 and .520(b)(1)(iii) outline several other purposes for which our practice may use or disclose protected information. For example, our practice may use or disclose protected information for the purposes of (1) conducting training programs in which student, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, (2) providing appointment reminders to patients, (3) providing treatment alternatives or other health-related benefits and services that may be of interest to patients, and (4) contacting patients to raise funds.

Disclosures to the Patient by Fax and E-mail

Periodically, patients request that our clinic transmit protected information to them by means of fax or email, or leave a message on voice mail regarding such information. While we may request specific written authorization from you prior to disclosing protected information through such means, you hereby agree (1) that by providing us with a fax number, email address, or phone number which includes voice mail, you are hereby consenting to disclosures through such means, and (2) in the even that you receive protected information from us via such means AND you do not wish to receive any more communications in these or other fashions, you agree that you will immediately instruct us in writing not to continue disclosing your protected information through such means.

Under Federal Law, how might your protected health information need to be used/ disclosed in ways that don't require written consent or authorization?

Under certain circumstances, law may require or permit our practice to make use of or to disclose your protected information without your consent or authorization. Such circumstances include:

a) Uses and disclosures required by law.
b) Uses and disclosures for public health activities.
c) Disclosures about victims of abuse, neglect, or domestic violence.
d) Uses and disclosures for health oversight activities.
e) Disclosures for judicial and administrative proceedings.
f) Disclosures for law enforcement purposes.
g) Uses and disclosures about decedents.
h) Uses and disclosures for cadaveric organ, eye or tissue donation purposes.
i) Uses and disclosures for research purposes.
j) Uses and disclosures to avert a serious threat to health or safety.

k) Uses and disclosures for specialized government functions.
l) Disclosures for workers' compensation.

What happens if other law is more restrictive than Federal Law?

In the event other law becomes more restrictive than Federal Law with respect to uses and disclosures of your protected information, our practice will include descriptions of the more stringent requirements in this privacy notice.

All other uses/ Disclosures require your written authorization

All other uses and disclosures besides those listed herein and those which require an opportunity to agree or object (see CFR 164.512) will only be made with your written authorization. Once such authorization is granted, you may revoke it at any time as provided by and subject to 45 CFR 164.508(b)(5).

Your Rights and How to Exercise Those Rights

Under Federal Law, you have the following rights. To exercise your rights, you will need to send a written request to the attention of the Privacy Officer of our clinic.

-You have the right to request restrictions on certain uses and disclosures of protected health information as provided by s 164.552(a). Please note however that under Federal Law, our clinic is not required to agree to a requested restriction.
-You have the right to receive confidential communications of protected health information as provided by and subject to 45 CFR s 164.522(b).
-You have the right to inspect and copy protected health information as provided by and subject to 45 CFR s 164.524.
-You have the right to receive an accounting of disclosures as provided by and subject to 45 CFR s 164.526.
-You have the right to receive an accounting of disclosures of protected health information as provided by and subject to 45 CFR s 164.528
-You have the right to obtain a copy of this privacy notice.

Duties of Our Clinic

Our clinic is required by law to maintain the privacy of your protected information and to provide you with notice of our legal duties and privacy practices concerning your protected information. Our clinic is required to abide by the terms of this privacy notice currently in effect. Our clinic reserves the right to change the terms of the notice and to make new notice provisions effective for all protected information that our clinic maintains. The revised notice will be made available at the front desk of our clinic for your inspection or copying.

Complaints

Our clinic welcomes any suggestions for amending our privacy practices. If you believe that your privacy rights have been violated, you may file a complaint with the Privacy Officer of our clinic and to the Secretary of Health and Human Services. To file a complaint with our Clinic's Privacy Officer, simply request and complete a copy of our privacy complaint form and submit it to our Privacy Officer. No individual may be retaliated against for filing such a complaint.

Contact Information or Further Information

For more information, call our main office number and ask to speak with our Privacy Officer.

CONTROLLED and PAIN MEDICATIONS AGREEMENT (File on top of flow sheet.)

The following agreement relates to my use of medications prescribed for pain control by

Wol+Med Clinics

I understand that taking medications in excess of or in addition to those prescribed may create a risk of harm to me, including but not limited to physical injury, addictive behavior, and a lessened effectiveness of the prescribed medication. I understand that the rules stated below are for my benefit.

I recognize that there are federal, state, and individual physician and/or clinic policies regarding the use of controlled substances or addictive medications. The Texas Intractable Pain Treatment Act, the Texas State Board of Medical Examiners, and the Texas State Board of Pharmacy all have specific requirements for the use of controlled substances and addictive medications for the treatment of chronic, intractable pain. I understand that the Physician and/or facility identified above is under no obligation to provide me with these classes of medications. I further understand that I will be provided with controlled substances and addictive medications while actively participating in this program only if I adhere to the following requirements:

1. I will use the substances only in the amount, and as prescribed and as directed by Wol+Med.
2. All controlled substances, prescription medications, or addictive medications will be prescribed only by Wol+Med. I will not use any controlled substances, prescription medications or addictive medications under any circumstances without obtaining the express permission of Wol+Med. Information that I have been receiving these substances from any other source or from "doctor shopping" may lead to a discontinuation of medications and treatment and/or discharge from this practice.
3. I agree to submit to urine and blood screens to detect the use of substances not prescribed through Wol+Med at the request of Physician.
4. I recognize that chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, and behavioral medicine strategies. I also recognize that active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program as directed by Physician to secure increased functioning and improved coping with my condition.
5. I will use only one pharmacy (name = ______________________________) for controlled substances. I authorize Physician and/or the facility identified above to provide my pharmacist with a copy of this agreement.
6. I agree to notify Physician promptly of any other physician or other health care provider that provides me with treatment outside the scope of this program.

7. I AGREE THAT FAILURE TO FOLLOW THE ABOVE REQUIREMENTS MAY RESULT IN A DISCONTINUATION OF MEDICATIONS AND TREATMENT.

I further understand that Physician and/or the facility identified above is not responsible for medicines or treatments prescribed by other health care providers. I understand that it if appears to the physician identified above that there is no improvement in my daily function or quality of life from the medication, I may be required to gradually taper my medication as prescribed and directed by the physician. I will not hold Physician, the facility identified above or any of its employees and/or agents liable for problems caused by discontinuation of medications.

PLEASE NOTE:

1. The physician will not refill the prescription before it is due.
2. If the medication is taken in a manner other than that prescribed, the physician reserves the right to refuse to refill the prescription.
3. Medications which are lost, stolen, etc., will not be refilled early.
4. Should the patient fail to fulfill any of the above listed obligations, the doctor reserves the right not to refill the prescription.
5. Controlled or addictive medications will not be refilled after office hours, on Sundays, or on holidays. It is the responsibility of the patient to keep up with their medication and the amount remaining. The office should be notified at least three days in advance before a refill is due so the patient can be scheduled for an office visit prior to the time of running out of medication. "Emergency" narcotic or addictive medication requests are directed to the local emergency room.
6. No controlled medications will be called into the pharmacy, you must make appointment.

________________________________ ______/______/______

Patient's signature Date

____

Witness

Intake Discharge Form - Physician Portion **ONLY**

Physicians complete this section on intake with as much information as possible. Complete the missing portions of this section on the last treatment date. Use the last treatment date for all dates.

List all ICD-9 codes diagnosed: ______________________________

List all CPT codes used: ______________________________

Total number of treatment dates: __________ Last treatment date: __________

Has a displaced disk been identified as well as individual Cervical, Thoracic and Lumbar Sprain/Strain, Ligamentous, Prolapse, Bulge, Protrusion, Herniation, Dislocation or Fracture?

If so, enter displaced disk into **NECK and BACK** section.
Enter each individual body part injury separately into **OTHER INJURIES** including Sprains/Strains.

Which of the following items were identified throughout the treatment:
(Last date noted could be the last treatment date or today and ongoing on the date of this report)

	Initial Date Noted	Last Date Noted
☐ Range of Motion	______	______
☐ Headaches	______	______
☐ Spasms	______	______
☐ Dizziness	______	______
☐ Visual Disturbance	______	______
☐ Sleep Disruption	______	______
☐ Radiating	______	______
☐ Anxiety/Depression	______	______
☐ TMJ	______	______
☐ Home Exercises	______	______
☐ Bed Rest	______	______
☐ Gym	______	______
☐ Home Traction	______	______
☐ Tens	______	______

ALL ITEMS BELOW MUST BE VALIDATED BY A MEDICAL DOCTOR

Determine future treatment determined necessary as either Probable (51 to 75% medically certain of it occurring) or Definite (76 to 100% medically certain.)
Number of treatments over next:
6 months ______ 12 months ______ 18 months______ 24 months______
Total cost of expected treatment ______________

Is your final prognosis, "Ongoing Complaints with Ongoing Treatment: ☐Yes ☐No
Ongoing treatment would include both Passive and Active Treatments.

Indicate which body part has reached MMI:______________
% Whole Body Impairment Rating:______________

Duties Under Duress:

Work ☐ Study ☐ Domestic Duties ☐ Household Duties ☐ Hobbies ☐

Loss of Enjoyment:

Work ☐ Study ☐ Domestic Duties ☐ Household Duties ☐ Hobbies ☐ Sport ☐

Sports Categories: Regional Playing ☐ Competitive ☐ Social ☐ Any ☐

Signature of Physician ______________________ Date Completed __________

Patient Name: ____ Date ___/___/20___

Duties Under Duress Summary

Complete the following questionnaire as it relates to how your injury(s) affect your performance of your living and work duties. Place a check in front of the date to day living duties which are painful or difficult for you to perform as a result of the injuries you sustained in the motor vehicle collision. Then check mark the appropriate box designating reason for difficulty. Include those duties/responsibilities which require that you reduce the time you are capable of performing them.

Job description: ____

N/A	**Work**	**Reason for the difficulty**
______	Lifting	☐ Increased Pain ☐ Restricted movement ☐ Weakness
______	Bending	☐ Increased Pain ☐ Restricted movement ☐ Weakness
______	Sitting	☐ Increased Pain ☐ Restricted movement ☐ Weakness
______	Walking	☐ Increased Pain ☐ Restricted movement ☐ Weakness
______	Computer duties	☐ Increased Pain ☐ Restricted movement ☐ Fatigue
Other:______________		☐ Increased Pain ☐ Restricted movement ☐ Weakness

N/A	**Studies/School**	**Reason for the difficulty**
______	Lifting	☐ Increased Pain ☐ Restricted movement ☐ Weakness
______	Bending	☐ Increased Pain ☐ Restricted movement ☐ Weakness
______	Sitting	☐ Increased Pain ☐ Restricted movement ☐ Weakness
______	Walking	☐ Increased Pain ☐ Restricted movement ☐ Weakness
______	Computer duties	☐ Increased Pain ☐ Restricted movement ☐ Fatigue
______	Studying	☐ Increased Pain ☐ Restricted movement ☐ Fatigue
Other:______________		☐ Increased Pain ☐ Restricted movement ☐ Weakness

N/A	**Domestic Duties**	**Reason for the difficulty**
______	Vacuuming	☐ Increased Pain ☐ Restricted movement ☐ Fatigue
______	Taking care of kids	☐ Increased Pain/Anxiety ☐ Restricted movement ☐ Fatigue
______	Cleaning	☐ Increased Pain ☐ Restricted movement ☐ Fatigue
______	Preparing Meals	☐ Increased Pain ☐ Restricted movement ☐ Fatigue
______	Other:______	☐ Increased Pain/Anxiety ☐ Restricted movement ☐ Fatigue

N/A	**Household Duties**	**Reason for the difficulty**
______	Yardwork	☐ Increased Pain ☐ Restricted movement ☐ Fatigue
______	Transportation	☐ Increased Pain/Anxiety ☐ Restricted movement ☐ Fatigue
______	Shopping	☐ Increased Pain/Anxiety ☐ Restricted movement ☐ Fatigue
______	Taking out trash	☐ Increased Pain ☐ Restricted movement ☐ Weakness
______	Other:______	☐ Increased Pain/Anxiety ☐ Restricted movement ☐ Fatigue

Patient Name: ______________________________ Date ___/___/20___

Loss of Enjoyment Summary

Complete the following questionnaire as it relates to the activities (work related or otherwise) you normally would be **enjoying** – but are currently not enjoying as a result of your injury(s).
Include all activities which you:

- can no longer do or perform, and/or
- cannot do or perform as often as you did before your injury

Job description: ______________________________

N/A	**Work**	**Reason for the difficulty**
______	Lifting	☐ Increased Pain ☐ Restricted movement ☐ Weakness
______	Bending	☐ Increased Pain ☐ Restricted movement ☐ Weakness
______	Walking	☐ Increased Pain ☐ Restricted movement ☐ Fatigue
______	Computer duties	☐ Increased Pain ☐ Restricted movement ☐ Fatigue
Other:	______________	☐ Increased Pain/Anxiety ☐ Restricted movement ☐ Fatigue

N/A	**Studies/School**	**Reason for the difficulty**
______	Lifting	☐ Increased Pain ☐ Restricted movement ☐ Weakness
______	Bending	☐ Increased Pain ☐ Restricted movement ☐ Weakness
______	Sitting	☐ Increased Pain ☐ Restricted movement ☐ Fatigue
______	Walking	☐ Increased Pain ☐ Restricted movement ☐ Fatigue
______	Computer duties	☐ Increased Pain ☐ Restricted movement ☐ Fatigue
______	Studying	☐ Increased Pain ☐ Restricted movement ☐ Fatigue
Other:	______________	☐ Increased Pain ☐ Restricted movement ☐ Fatigue

N/A	**Domestic Duties**	**Reason for the difficulty**
______	Vacuuming	☐ Increased Pain ☐ Restricted movement ☐ Fatigue
______	Taking care of kids	☐ Increased Pain/Anxiety ☐ Restricted movement ☐ Fatigue
______	Cleaning	☐ Increased Pain ☐ Restricted movement ☐ Fatigue
______	Preparing Meals	☐ Increased Pain ☐ Restricted movement ☐ Fatigue
______	Other:______	☐ Increased Pain ☐ Restricted movement ☐ Fatigue

N/A	**Household Duties**	**Reason for the difficulty**
______	Yardwork	☐ Increased Pain ☐ Restricted movement ☐ Fatigue
______	Transportation	☐ Increased Pain/Anxiety ☐ Restricted movement ☐ Fatigue
______	Shopping	☐ Increased Pain/Anxiety ☐ Restricted movement ☐ Fatigue
______	Taking out trash	☐ Increased Pain ☐ Restricted movement ☐ Weakness
______	Other:______	☐ Increased Pain ☐ Restricted movement ☐ Weakness

N/A	**Sports**	**Reason for the difficulty**
Name Sport:	____________	☐ Increased Pain ☐ Restricted movement ☐ Weakness

Pre-accident level of participation: ☐Socially ☐Competitively ☐Professionally

APPLICATION FOR BENEFITS — AUTOMOBILE PERSONAL INJURY PROTECTION

NAME OF INSURANCE COMPANY

DATE	OUR POLICY HOLDER	POLICY NUMBER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE TEXAS AUTOMOBILE PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

TO: ______________________________
CLAIM DEPT.

YOUR NAME	PHONE NO.	HOME	BUSINESS
YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	

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

BRIEF DESCRIPTION OF ACCIDENT AND AUTOMOBILE YOU OCCUPIED, OR WERE STRUCK BY.

OTHER AUTOMOBILES IN YOUR FAMILY

AUTO:	OWNER:	INSURED:
1 ______	1 ______	1 ______
2 ______	2 ______	2 ______
3 ______	3 ______	3 ______

ARE YOU A MEMBER OF OUR POLICY HOLDER'S HOUSEHOLD? ☐ YES ☐ NO

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

SIGNATURE DATE

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR? ☐ YES ☐ NO	DATE OF 1st TREATMENT	DOCTOR'S NAME AND ADDRESS

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

AMOUNT OF MEDICAL BILLS TO DATE $	WILL YOU HAVE MORE MEDICAL EXPENSES? ☐ YES ☐ NO	AT THE TIME OF THIS ACCIDENT WERE YOU WORKING FOR YOUR EMPLOYER? ☐ YES ☐ NO
DID YOU LOSE TIME FROM WORK AS A RESULT OF YOUR INJURY? ☐ YES ☐ NO	IF YES, AMOUNT LOST TO DATE	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY $

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR WAGE LOSS AND/OR MEDICAL BENEFITS UNDER
(1) ANY WORKMEN'S COMPENSATION LAW? ☐ YES ☐ NO
(2) ANY OTHER SOURCE? ☐ YES ☐ NO (name)
IF YES, AMOUNT OF MEDICAL & WAGE $ ☐ PER WEEK ☐ PER MONTH

LIST NAMES AND ADDRESSES OF YOUR EMPLOYERS AT THE DATE OF THE ACCIDENT OR LAST PREVIOUS EMPLOYER AND GIVE OCCUPATION AND DATES OF EMPLOYMENT.

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? ☐ YES ☐ NO IF YES, EXPLAIN ON REVERSE SIDE.

SIGNATURE DATE

IMPORTANT:
1. **TO PRESENT CLAIM FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.**
2. **YOU MUST ALSO SIGN ANY ATTACHED AUTHORIZATION(S).**
3. **RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.**

RE-ORDER FORM A-180T
from- G.A.THOMPSON CO.
1(800) 527-0340
www.gathompson.com

APPLICATION FOR BENEFITS — AUTOMOBILE PERSONAL INJURY PROTECTION

NAME OF INSURANCE COMPANY

DATE	OUR POLICY HOLDER	POLICY NUMBER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE TEXAS AUTOMOBILE PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

TO: ______________________
CLAIM DEPT.

YOUR NAME | PHONE NO. HOME | BUSINESS

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

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

BRIEF DESCRIPTION OF ACCIDENT AND AUTOMOBILE YOU OCCUPIED, OR WERE STRUCK BY.

OTHER AUTOMOBILES IN YOUR FAMILY

AUTO: 1 ______ 2 ______ 3 ______
OWNER: 1 ______ 2 ______ 3 ______
INSURED: 1 ______ 2 ______ 3 ______

ARE YOU A MEMBER OF OUR POLICY HOLDER'S HOUSEHOLD? ☐ YES ☐ NO

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

SIGNATURE DATE

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR? ☐ YES ☐ NO | DATE OF 1st TREATMENT | DOCTOR'S NAME AND ADDRESS

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

AMOUNT OF MEDICAL BILLS TO DATE $ | WILL YOU HAVE MORE MEDICAL EXPENSES? ☐ YES ☐ NO | AT THE TIME OF THIS ACCIDENT WERE YOU WORKING FOR YOUR EMPLOYER? ☐YES ☐ NO

DID YOU LOSE TIME FROM WORK AS A RESULT OF YOUR INJURY? ☐YES ☐ NO | IF YES, AMOUNT LOST TO DATE | WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY $

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR WAGE LOSS AND/OR MEDICAL BENEFITS UNDER
(1) ANY WORKMEN'S COMPENSATION LAW? ☐ YES ☐ NO
(2) ANY OTHER SOURCE? ☐ YES ☐ NO (name)
IF YES, AMOUNT OF MEDICAL & WAGE $ ☐ PER WEEK ☐ PER MONTH

LIST NAMES AND ADDRESSES OF YOUR EMPLOYERS AT THE DATE OF THE ACCIDENT OR LAST PREVIOUS EMPLOYER AND GIVE OCCUPATION AND DATES OF EMPLOYMENT.

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? ☐ YES ☐NO IF YES, EXPLAIN ON REVERSE SIDE.

SIGNATURE DATE

IMPORTANT:
1. TO PRESENT CLAIM FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST ALSO SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

RE-ORDER FORM A-180T
from- G.A.THOMPSON CO.
1(800) 527-0340
www.gathompson.com