Main Line HealthCare
Occupational and Travel Health

Paoli: 484-565-1293 610-296-5437 (f)
Lankenau: 484-476-2881 484-476-2158 (f)

Workers Compensation
REGISTRATION/AUTHORIZATION FOR RELEASE OF INFORMATION

PLEASE PRINT

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

SOCIAL SECURITY #: _____-_____-_____

ADDRESS: _____

C ITY:_____ STATE:_____ ZIP:_____

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

HOME PHONE: _____-_____-_____

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: _____

PRIOR TO TODAY, WERE YOU SEEN ANYWHERE ELSE FOR THIS INJURY (ER/PHYSICIAN)? 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:_____

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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)*

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			Heart Palpitation/ Abn Beat			*Injury/Trouble with:*			Mumps		
Asthma			Hepatitis			Ankle			Rheumatic Fever		
Cancer/ Tumor			High Blood Pressure			Back			Scarlet Fever		
Diabetes			Kidney or Bladder Trouble			Elbow			Whooping Cough		
Dental Problems			Lung/Breathing Problems			Foot			MEN ONLY: Prostate/ Testicular problems		
Drug/Alcohol Dependency			Malaria/ Tropical Disease			Hand					
Depression/Anxiety			Pneumonia			Hip			WOMEN ONLY:		
Emotional/ Psychological Problems			Sexually Transmitted Disease			Knee			Irregular/ very painful periods		
Epilepsy/Seizures			Stomach Gastritis or Ulcers			Neck			Disorders of Ovaries Uterus/breast		
Head Injury/ Concussion			Stroke			Shoulder			Any Complications w/ pregnancy?		
Hearing or Ear Problem			Thyroid Condition			Wrist			# of Pregnancies		
Heart Attack (Myocardial Infarction)			Tuberculosis			Chicken Pox			Date of Last Normal Period		
Heart Disease/ Murmurs			Recent Changes in Weight in last 6-12 months			German Measles			Date of Last Pelvic exam		
						Measles			Date of Last Mammogram		

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

Yes No

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

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

☐ ☐ 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 System

Acknowledgement of Receipt of Notice of Privacy Practices

PATIENT NAME: _____
(Print full name)

DATE OF BIRTH: _____
(required)

By signing below, I acknowledge receipt of the *Notice of Privacy Practices* of Main Line Health System (MLHS)

Signature: _____ Date:_____

****

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
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining the acknowledgement
☐ Other (Please specify):

Signature of MLHS representative: _____Date:_____