

PERSONAL INFORMATION: PLEASE PRINT

MISS/MRS/MS/MR: _____ AGE: _____
FIRST MIDDLE MAIDEN LAST

DATE OF BIRTH: _____ / _____ / _____ MALE/FEMALE SINGLE / MARRIED / DIVORCED
MONTH DAY YEAR PLEASE CIRCLE ONE

MAILING ADDRESS: _____
NUMBER & STREET CITY STATE ZIP

HOME PHONE: () _____ SOCIAL SECURITY# _____

CELL/ALTERNATE: () _____

EMPLOYER INFORMATION: PLEASE PRINT

COMPANY NAME: _____ PHONE: _____
OCCUPATION: _____

ADDRESS NUMBER & STREET CITY STATE ZIP

SPOUSE INFORMATION: PLEASE PRINT

NAME: _____ OCCUPATION: _____
FIRST MIDDLE MAIDEN LAST

IN CASE OF EMERGENCY CONTACT: _____ RELATIONSHIP: _____
PHONE: _____ ALTERNATE: _____

*** IN ORDER THAT WE DO NOT HAVE TO REPEAT ANY TESTS THAT HAVE ALREADY BEEN PERFORMED, PLEASE OBTAIN ALL MEDICAL REPORTS, X-RAYS, PHYSICAL THERAPY REPORTS AND REHABILITATION REPORTS. THIS INFORMATION WILL ALSO PROVIDE NECESSARY DATES WHICH ARE NEEDED FOR A COMPLETE EVALUATION OF YOUR INJURIES AND ILLNESS.**

RELEASE OF MEDICAL RECORDS: PLEASE PRINT

*** I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND REQUEST PAYMENT OF ALL MEDICAL BENEFITS TO BE MADE DIRECTLY TO THE PHYSICIAN OR SUPPLIER LISTED ON THIS FORM.**

PATIENT SIGNATURE: _____ **DATE:** _____

*** PLEASE CIRCLE ONE OR BOTH - PHYSICIAN / ATTORNEY**

PHYSICIAN NAME: _____ PHONE: _____

ATTORNEY NAME: _____ PHONE: _____

*** I FURTHER AUTHORIZE INFORMATION TO BE RELEASED TO MY PHYSICIAN / ATTORNEY AS INDICATED ABOVE.**

PATIENT SIGNATURE: _____ **DATE:** _____

ACCIDENT INFORMATION:

PATIENT NAME: _____ DATE OF ACCIDENT: _____
TYPE OF ACCIDENT: CIRCLE ONE AUTO / BUS / RENTAL CAR / WORKERS COMP / FALL / OTHER: _____
DRIVER OR PASSENGER CIRCLE ONE NAME OF CAR OWNER: _____
RELATIONSHIP: _____

AUTO INSURANCE INFORMATION (PLEASE PRINT)

NAME OF INSURED: _____ RELATIONSHIP TO INSURED: _____
NAME OF INSURANCE COMPANY: _____
ADDRESS: _____ PHONE NUMBER: _____
HAS ACCIDENT BEEN REPORTED: _____ Y OR N CLAIM#: _____
POLICY#: _____

FOR OFFICE USE ONLY
ADJ: _____ DEDUCTIBLE MET: _____ Y OR N
COVERAGE INFO: _____ DEDUCTIBLE: _____ COVERAGE: 80% 100% MEDPAY: Y OR N

HEALTH INSURANCE INFORMATION (PLEASE PRINT)

NAME OF INSURED: _____ PATIENT I. D. # _____
DATE OF BIRTH INSURED: _____ GROUP # _____
RELATIONSHIP TO INSURED: _____ EFFECTIVE DATE: _____
EMPLOYER NAME: _____
NAME OF HEALTH INSURANCE COMPANY: _____
ADDRESS: _____ PHONE: _____

FOR OFFICE USE ONLY:
DED: _____ MET: _____ Y OR N COVERAGE: _____ OUT OF NETWORK BENEFITS: Y OR N

WORKERS COMPENSATION INFORMATION (PLEASE PRINT)

EMPLOYER'S NAME: _____ PHONE: _____
WORKER'S COMP. CARRIER: _____ FAX #: _____
ADDRESS: _____ ADJUSTER: _____

FOR OFFICE USE ONLY DOCTOR: _____

INFORMATION TAKEN BY: _____
DIAGNOSIS CODES: _____

CHAMBERS MEDICAL GROUP
2932 BRECKENRIDGE # 1
LOUISVILLE, KY 40220
(502) 479-1616 FAX (502) 479-1619

AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ **SS# Number:** _____

I hereby authorize the following Doctor, Office or Institution,

to release a copy of my protected health information to:

CHAMBERS MEDICAL GROUP
2932 BRECKENRIDGE # 1
LOUISVILLE, KY 40220
(502) 479-1616 FAX (502) 479-1619

Specific description of information requested:

All Medical Records X-ray Reports MRI Reports CT Reports Narrative Reports
 X-ray Films MRI Films Nerve Conduction / EMG Studies
 Emergency Room Records Hospital Inpatient Records Physical Therapy Records

Other: _____

Dates: From _____ To: _____

1. The provider must complete the following statement:

a. Will the healthcare provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes No XXX

2. The patient must read and initial the following statement:

a. I understand that I may request a copy of this form after I sign it. Pt. initials _____

Section C: Must be completed for all authorizations

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on ___/___/___ (DD/MM/YYYY) Initials: _____

2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any affect on any actions that took place before they received the revocation. Initials: _____

Signature of patient or patient's representative
(Form *MUST* be completed before signing)

Date

Printed name of patient's representative: _____

Relationship to the patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Patient Name: _____ Date of Accident: _____

Patient Injury Identification

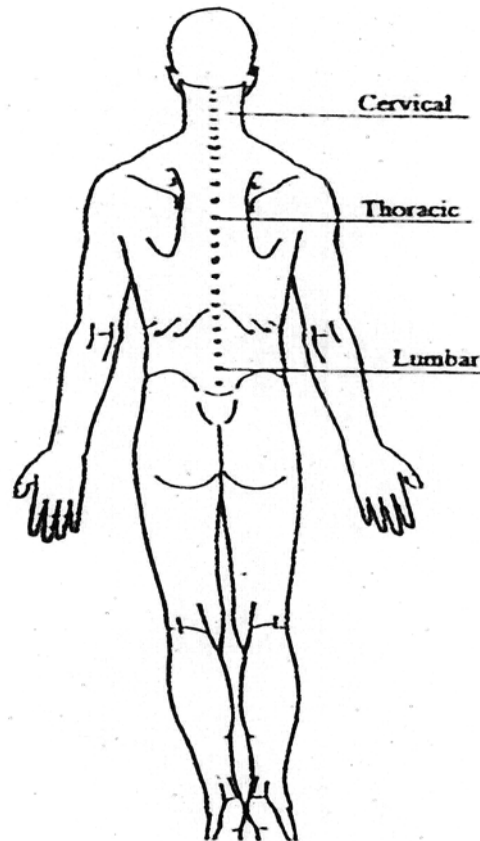
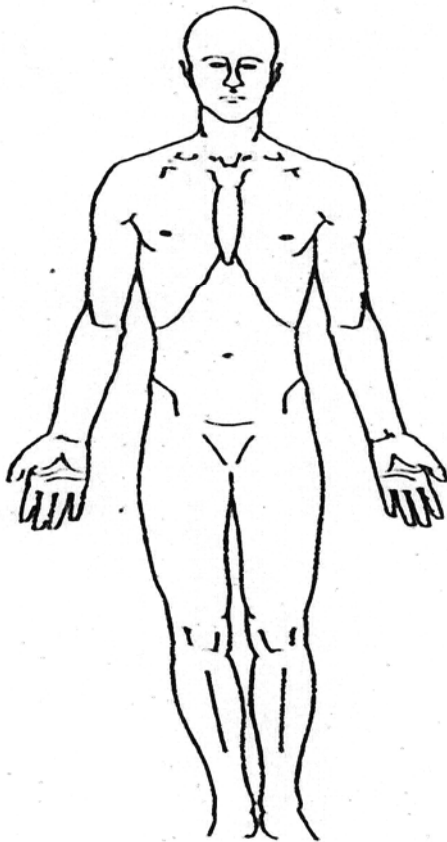
Draw or shade in the location of your body injuries as a result of your most recent accident. Describe, by connecting a line to the area of the body diagram. Note pain, stiffness, weakness, numbness, cuts, black and blue marks, swelling and scars. Carefully scan your entire body pushing on areas to note tenderness. Move arms, legs, back including pain during activities such as lifting, bending and working. This is very important so the physician doesn't overlook any injuries.

RIGHT

LEFT

LEFT

RIGHT



CHECK THE APPROPRIATE BOX FOR ANY SYMPTOMS THAT APPEARED AS A RESULT OF THE ACCIDENT/INJURY:

- | | | |
|---|--|--|
| <input type="checkbox"/> Headache
<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Mid Back Pain
<input type="checkbox"/> Low Back Pain
<input type="checkbox"/> Shoulder Pain L/R | <input type="checkbox"/> Elbow Pain L/R
<input type="checkbox"/> Wrist/Hand Pain L/R
<input type="checkbox"/> Hip Pain L/R
<input type="checkbox"/> Knee Pain L/R
<input type="checkbox"/> Ankle/Foot Pain L/R | <input type="checkbox"/> Numbness of _____
<input type="checkbox"/> Tingling of _____
<input type="checkbox"/> Sleep Difficulties
<input type="checkbox"/> Jaw Pain L/R
<input type="checkbox"/> Other _____ |
|---|--|--|

CHAMBERS MEDICAL GROUP
INFORMED CONSENT TO TREATMENT

The purpose of this form is to make you, the patient, aware of the possible risks of the different treatment modalities routinely provided at Chambers Medical Group. If you are referred to one or our specialists (orthopedic surgery, interventional pain management, etc.) they will have an additional form to advise you of the risks of their procedures.

MEDICATION: possible risks include allergic reaction, dependence, liver and kidney function problems, affects on heart, drowsiness, etc. Caution should be used as medication can mask progress, and the danger of side effects and damage to the health of the person taking the medication is well documented. Risk probability is moderate.

THERAPY: possible risks include burns induced by heat (causing temporary pain and possible blistering), temporary pain due to massage or adjunctive therapies. Risk probability is extremely rare.

TRIGGER POINT INJECTIONS: possible pneumothorax, localized reaction to medication, allergic reaction. Risk probability is extremely rare.

CHIROPRACTIC CARE: possible fracture of bone, sprain of ligament, strain of muscle, cerebrovascular injury (stroke) could occur upon severe injury to the arteries of the neck with an extension-rotation-thrust atlas adjustment - that type of adjustment is NOT performed in our offices. Risk probability is extremely rare.

OTHER PROBLEMS: there may be other problems or complications arising from treatment such as massage, traction, etc., other than noted above. These other problems occur so rarely it is not possible to anticipate/explain them in advance. Risk probability is extremely rare.

ALTERNATIVE TREATMENTS

HOSPITALIZATION: proven expensive and exposes the patient to communicable disease and possible doctor/staff mishap. Risk probability is moderate.

SURGERY: risks include reaction to anesthesia, doctor error, and the risks imposed by hospitalization during convalescent period. Risk probability is substantial.

NON TREATMENT: can result in adhesions, pain, and reduction in joint mobility, which can lead to degenerative joint disease. Risk probability is moderate.

At **CHAMBERS MEDICAL GROUP** we use a system of health care delivery. As with any health care system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable we will refer you to another provider who we feel will better assist your situation.

If you have any questions about the above information, please ask your doctor. When you have a full understanding of this consent form, please sign below and date below.

I hereby authorize and direct **CHAMBERS MEDICAL GROUP** to provide such service as they deem reasonable and necessary.

I HEREBY STATE THAT I HAVE READ THIS CONSENT FORM.

Patient

Witness

Date

Chambers Medical Group

Patient Questionnaire

Patient Name _____ Age _____ Date _____

1. Accident/Injury Type: Auto, Slip/Fall, On Job Injury, Other (Please specify) _____

2. Date of Accident/Injury: _____ Location: _____

3. Were you wearing a seatbelt Y or N were you the Driver Passenger Front seat Back seat

4. In your own words, please describe the accident/injury. _____

5. Were you struck in the: Front, Rear, Driver's side, Passenger's side?

6. Were you knocked unconscious? Yes, No. If yes for how long? _____

7. Did you feel pain immediately after the accident? Yes No.....If yes please describe _____

8. Were you examined by paramedics after the accident? Yes No

9. Did you go to the hospital? Yes No If yes, name of Hospital _____

How did you get there? Ambulance Self Driven by _____

10. Were X-Rays taken? Yes, No. Were you given medication? Yes, No

11. Were you told the diagnosis? Yes, No....If yes please describe _____

12. Have you been treated by another Dr. since the accident? Yes, No.....If yes please list the Dr's name and address: _____

What treatment did you receive? _____

13. Since the injury occurred, are your symptoms: Improving Getting Worse Staying same

14. Have you ever had similar symptoms prior to the accident/injury? Yes No. Please describe _____

15. Have you ever been involved in an accident before? Yes No....If yes please describe, including dates and injuries. _____

16. Have you ever had any surgeries? Yes, No....If yes please describe _____

If yes, do you have any surgical implants? (such as metal rods, pacemaker) _____

17. Do you have any health problems we need to know about (including any allergies to medications)?

Yes, No. Please describe _____

18. Allergies? _____

19. Current medications? _____

20. Pregnant? Yes No (if yes, expected due date.) _____

21. Have you lost time from work as a result of this accident? Yes, No.....If yes please complete these questions: a) Dates missed / / through / / . b) Type of work _____

22. If this was an auto accident how many people were in the car? _____

Designation of Authority for Third-Party Complaints

Please accept the complaint filed with the Office of Insurance on my behalf by Paul Brosky (Vice President of Operations, Chambers Medical Group), Lisabeth Chambers (President, Chambers Medical Group), Collette Garrett (Kentucky Operations) as having been filed with my consent.

I hereby designate the individuals named above as my authorized representative for the purposes of filing and investigating my complaint.

I authorize the Consumer Protection & Education Division of the Kentucky Office of Insurance to investigate the complaint received on my behalf and to respond directly to:

My authorized representative (Chambers Medical Group as indicated above).

Me

Insured's signature: _____

Insured's name: _____
(PLEASE PRINT)

Insured's phone #: (_____) _____ - _____

Date: _____

APPLICATION FOR BENEFITS - PERSONAL INJURY PROTECTION KENTUCKY NO-FAULT

- IMPORTANT:**
1. To enable us to determine if you are entitled to benefits under the policyholder's contract, you must complete and sign this form.
 2. You must also sign the attached authorization(s).
 3. Return promptly with any medical bills you have received to date. However, you should not wait for your medical bills to arrive before sending this application to us. Please send this application back immediately.

DATE OUR POLICYHOLDER DATE OF ACCIDENT FILE NO.

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.

_____ Claim Dept.

YOUR NAME HOME PHONE NUMBER WORK PHONE NUMBER

YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)

DATE OF BIRTH SOCIAL SECURITY NUMBER

DATE AND TIME OF ACCIDENT:

BRIEF DESCRIPTION OF ACCIDENT:

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

PLEASE LIST ALL AUTO INSURANCE CARRIERS CURRENTLY COVERING ANY OR ALL OF THE VEHICLES YOU OWN NAME OF INSURANCE COMPANY AND POLICY # :

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 NO-FAULT COVERAGE (I.E. PERSONAL INJURY PROTECTION COVERAGE) AS PROVIDED BY THE KENTUCKY NO-FAULT ACT (KAS304.39) BY SIGNING A REJECTION FOR THIS COVERAGE? YES NO

WERE YOU INJURED AS A RESULT OF THIS ACCIDENT 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

DOCTOR'S NAME AND ADDRESS:

IF YOU WERE TREATED IN A HOSPITAL WERE YOU AN IN-PATIENT OUT-PATIENT

HOSPITAL'S NAME AND ADDRESS:

AMOUNT OF MEDICAL BILLS TO DATE: \$

WILL YOU HAVE MORE MEDICAL EXPENSES? YES NO

AT TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES NO

DID YOU LOSE WAGES OR SALARY AS RESULT OF YOUR INJURY? YES NO

IF YES, AMOUNT TO DATE:

WHAT IS YOUR AVERAGE WEEKLY WAGE/SALARY?

IF YOU LOST WAGES, DATE DISABILITY FROM WORK BEGAN:

DATE YOU RETURNED TO WORK:

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER:

WORKMEN'S COMPENSATION LAWS?	YES	NO
SOCIAL SECURITY BENEFITS?	YES	NO

IF YOU ARE CLAIMING LOST WAGES, COMPLETE THIS SECTION, DOING SO WILL HELP US PROMPTLY VERIFY YOUR SALARY RATE WITH YOUR EMPLOYER.

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

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

HAVE YOU HAD ANY OTHER EXPENSES AS A RESULT OF YOUR INJURY? YES NO

IF YES, EXPLAIN:

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

Signature

Date