FEDERAL
INJURY CENTERS

DOL NEW PATIENT INFORMATION SHEET

Date:	Patient Account #:
Patient Name:	Date of Injury:
Home Phone:	Cell Phone:
Email Address:	
Patient's Address:	
How did you hear about us?	
DOB:	SS#:
Injured Body Area:	
Employer (Agency):	
Employers Address:	
Employer Phone Number:	Supervisor's First and Last Name:
What is Your Craft:	
Case #:	
Claim Examiner's First and Last Name:	
Claim Examiner's Phone Number:	
Have you filed a CA1 or CA2?	
Did your supervisor give you a CA17 to bring with you (Duty Status Report)?	
Did your supervisor give you a CA16 to bring with you? (Authorization for Examination/Medical Treatment)	
Treating Doctor Name:	Phone Number:
Have you had any therapy?	If Yes, How much and when?
Have you had surgery?	If Yes, when?
Appointment Date:	Appointment Time:
Associate Initials:	
Do you have any other work injuries we can help you with?	

REMINDER TO PATIENTS

- Bring all your medical records for this injury to your visit, however, if you cannot gather everything prior to the appointment please come anyway. Remind them of date and time of appt.
- Bring any and all letters and other correspondence you have received from the Department of Labor.
- Bring all forms given to you by your supervisor (including the receipt for the CA1 / CA2)
- Bring the receipt (Page 3 or Page 4) for your CA1 / CA2.

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Patient Questionnaire:

For **Traumatic** Injuries. answer Question number **1.**
For **Repetitive** Conditions, answer Questions number **1** and **2.**

1. Describe in detail the employment-related activities which you believe contributed to your condition.
2. When did you first notice it? Has it come and gone, or has it been present continuously? What symptoms have you experienced?
3. Have you Sought out medical attention for this injured body part in the past? If yes....when?
4. Do you have another job or any activities, such as hobbies, that could have contributed to this injury?

Alta Health Services, Inc
520 Providence Hwy, Suite 8, Norwood Ma 02062

PATIENT POLICIES

_____I understand I am required to provide this office ALL documentation whether sent to my agency by me or my representative or received from my agency irrespective of whether I believe it to be important or not so it may be reviewed for action items and added to my file.

_____I understand I am required to provide this office ALL documentation whether sent to OWCP by me or my representative or received from OWCP irrespective of whether I believe it to be important or not so it may be reviewed for action items and added to my file.

_____I understand my treatment may be terminated, paused or postponed should I not provide all documentation required of me for the acceptance of my case. I will promptly respond to any and all inquiries from my agency and OWCP.

_____I understand this office bills OWCP directly for my care after the claim has been approved by OWCP. The issuing of a claim number does not mean or indicate your claim has been accepted by OWCP. Should I not provide documentation to this office which is required for approval (employee statements/narrative, factual data, information requests, imaging and diagnostic information, denial letters, appeal forms etc.) or timely processing of my claim that I will be personally liable for any and all fees associated with my care as this office does not accept any other insurance other than OWCP. I understand I simply need to provide all requested documentation or information in order to not be personally liable for any and all fees.

_____I understand it is my responsibility to call OWCP to verify the receipt of documentation, case status updates and at the request of the staff and will record it on the provided call log.

_____I understand that while this office will help in assisting me with my claim and provide claim management it is ultimately my responsibility to provide my agency and OWCP with requested information and documentation. I will provide my agency with all Ca-17 Duty Status Reports and all supporting documentation when submitting claims for compensation by use of form CA-7 and CA-7a. I further understand that all information provided to me as claim management is not legal advice and does not replace the advice of an attorney.

_____I understand that missing appointments will impact my case negatively, and therefore, will reschedule all appointments at the next available time.

_____I completely understand the above and have asked any question needed for clarification prior to signing this form.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

I hereby allow _____ to be included in my care, examinations and treatment.
SCDL attached: yes no

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____