REV. 10.08.2019

ALLEGHENY MEDICAL
COMPLETE CARE. ONE PLACE.
alleghenymedical.com

DAY	Date	Time
DOC:		Acct#
Conf: Yes No		Staff:

AUTO ACCIDENT/PERSONAL INJURY INTAKE FORM

Full Legal Name: _____ /_____ /_____
Last Name *First Name* *Middle Initial*

Age: _____ Date of Birth: _____ /_____ /_____ S.S. #: _____-_____-_____

Address:_____ City: _____ State: ___ Zip: _____

(H) Phone # (____)_____ Mobile # (____)_____ Best # to reach you ☐ H or ☐ M

E-mail address: _____ Gender: Female ☐ (Pregnant? ☐) Male ☐

Single ☐ Married ☐ Other ☐ Spouse or Partner Name: _____

Employer / School: _____ Phone# (_____)_____

Address: _____ City: _____ State: ___ Zip: _____

Occupation: _____ check which applies: ☐Full time ☐Part time ☐Student ☐Retired

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Phone# (_____)_____

Other than yourself, to whom may we disclose your Protected Health Information? _____

PCP AND CURRENT PHARMACY INFORMATION: (if no PCP, please put N/A in "Family MD" area)

Family MD _____ Phone # _____

Pharmacy _____ Phone # _____

What is the best way to communicate with you between office visits? (Select all that apply)
(Select the form of communication desired is confirming consent)

☐E-mail ☐Home ☐Work ☐Cell Phone ☐Text

How were you referred to us? _____

How did you hear about us? ☐ TV ☐ Billboard ☐ Radio ☐ Internet ☐ Other_____

Do we have consent to call you: ☐ Yes ☐ No On What Number? ☐ Home ☐ Mobile

What is the best time to reach you? ☐ Morning ☐ Afternoon ☐ Evening

Is there any place you do NOT want me to leave a message?_____

**Please be aware that e-mails not a secure form of communication and that the discussion of our medical care will become a part of your medical record.*

PATIENT NAME:

DAY	Date	Time
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HEALTH INSURANCE INFORMATION:

PLEASE PROVIDE YOUR INSURANCE CARD(S) TO FRONT DESK FOR SCANNING/COPYING

Do you have medical insurance? Yes ☐ No ☐
Do you have Medicare? Yes ☐ No ☐
Insurance Company Name _____
Insurance Company Phone_____

Type of Insurance:☐HMO☐PPO☐POS☐OTHER

Policy#_____ Group#_____

Policy Holders Name _____

Their DOB:_____ Relationship _____

Do have any other insurance? Yes ☐ No ☐
If Yes, complete below;
Insurance Company Name _____
Insurance Company Phone_____

Type of Insurance:☐HMO☐PPO☐POS☐OTHER

Policy#_____ Group#_____

Policy Holders Name _____

Their DOB:_____ Relationship _____

What are the concerns for which you are seeking care today? (Primary concern first)

1. _____ Date of onset: _____
2. _____ Date of onset: _____
3. _____ Date of onset: _____
4. _____ Date of onset: _____

MEDICATIONS AND SUPPLEMENTS:

What medications (prescribed or over the counter) are you currently taking? Including Vitamins?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you currently taking any of the following (please check all that apply): ☐asprin ☐ibuprofen ☐ other _____

Do you have any food or drug allergies; if so list them _____

The patient or legal guardian must sign authorizations, such as in the case of a minor or when the patient is physically or mentally incompetent to sign. If patient is able to sign by marking an X, legal guardian must witness signature.

PATIENT NAME:

AUTO ACCIDENT/PERSONAL INJURY:

Attention: If you were injured via an auto accident/personal injury, we ask that you provide Health Insurance information. We obtain this information as back up only, if for some reason, auto/personal injury info should deny your claim.

Was your injury (or injuries) related to: ☐ auto accident ☐ personal injury

Date of Injury: _____

Where did accident occur: _____

How did accident occur, describe in your own words?_____

_____

_____

Are you off work? ☐ Yes ☐ No

If yes, last day worked? ____/_____/_____

Who took you off work? _____ When? ____/____/_____

Who did you report this accident to? _____

Were you taken to the hospital: ☐ Yes ☐ No

If so, where? _____

How long were you hospitalized for? _____

If any, what other doctor(s) treated you since the accident: _____

Are you on any medications because of this accident? ☐ Yes ☐ No

If yes, describe: _____

How would you describe the pain you felt immediately following your injury?

☐ Grabbing feeling ☐ sharp pain in one spot ☐ sharp pain with radiating symptoms

☐ Popping feeling ☐ dull ache ☐ other _____

Please describe your current symptoms: _____

_____

Have you been treated by anyone for the injury or symptoms? ☐ Yes ☐ No

If yes, explain: _____

PATIENT NAME:

IF AUTO ACCIDENTS PLEASE ANSWER THE FOLLOWING:

At the time of accident, were you: ☐ driver ☐ front passenger ☐ back passenger

At the time of accident, were you: ☐ stopped ☐ slowing ☐ accelerating
☐ moving sideways ☐ moving in reverse

During first impact did another vehicle hit your vehicle ☐ Yes ☐ No

It is best described as: ☐ subcompact ☐ compact ☐ full size ☐ small truck
☐ full size truck ☐ motorcycle ☐ bus ☐ other _____

Did your vehicle hit something first? ☐ Yes ☐ No

If your vehicle hit something, what was it? ☐ another vehicle ☐ guard rail ☐ tree
☐ embankment ☐ other _____

Your vehicles first impact area was:

☐ Front passenger side corner ☐ Rear right side corner ☐ Head on
☐ Front passenger side ☐ Rear right side bumper ☐ other _____
☐ Front bumper ☐ Rear left side corner
☐ Front driver side corner ☐ Rear left side bumper

The vehicle I was in had a second impact? ☐ Yes ☐ No

If yes, describe: _____

At the time of accident, your vehicle was moving at ☐ moderate speed ☐ stopped ☐ other _____

At the time of accident, other vehicle was moving at ☐ moderate speed ☐ stopped ☐ other _____

Were you wearing a seat belt? ☐ Yes ☐ No

Was it also a shoulder belt? ☐ Yes ☐ No

Did the airbag deploy? ☐ Yes ☐ No

Did you hit your head w/ the steering wheel? ☐ Yes ☐ No

Were you expecting the impact? ☐ Yes ☐ No

Did you brace yourself? ☐ Yes ☐ No

PATIENT NAME:

Were you caught completely by surprise? ☐ Yes ☐ No

Were you looking right? ☐ Yes ☐ No

Were you looking left? ☐ Yes ☐ No

Were you looking straight ahead? ☐ Yes ☐ No

Were you looking back? ☐ Yes ☐ No

Did you hit the inside of the vehicle w/ another body part? ☐ Yes ☐ No

Describe: _____

If injury occurred differently than anything mentioned above, please describe: _____

_____

IF PERSONAL INJURY PLEASE ANSWER THE FOLLOWING:

My injury occurred when I ☐ was carrying object ☐ lifted an object ☐ sneezed ☐ coughed
☐ twisted at waist ☐ slipped & fell ☐ was looking over shoulder
☐ straightened up from bending

If you fell, choose all that apply ☐ surface was wet ☐ surface was icy ☐ surface has liquid on it
☐ Rug/carpet was uneven tripped ☐ over object on floor
☐ Other _____

If injury occurred differently than anything mentioned above, please describe: _____

_____

AUTO/PERSONAL INSURANCE INFORMATION:

Carrier Name: _____

Address: _____

Telephone # _____

Claim # _____

CAR INSURANCE MED PAY EXPENSE (PLEASE CHECK)

☐ $5,000 ☐ $10,000 ☐ More $ _____

How much has been used $ _____ How much is left _____

PATIENT NAME:

ATTORNEY INFORMATION:

Have you obtained an attorney? ☐ Yes ☐ No

If yes, Name: _____

Address: _____

Telephone # _____

During future visits at Allegheny Medical Integrated Medicine, you have available, a team of providers to assist you with your health care. Please mark those providers that you would be interested in seeing to help you reach all your health care needs.

☐ Primary Care ☐ Family Care ☐ Internal Medicine ☐ Nutrition

☐ Physical Therapy ☐ Chiropractic ☐ Orthopedic- Assoc/Provider

Please describe your current symptom(s) _____

Approximant date began _____

PATIENT NAME:

PAST HISTORY INFORMATION:

Please check any of the following, if any apply to you, currently or in the past:

☐ Physciatric Problem ☐ Poor Appetite

MEDICAL HISTORY:

GENERAL

Headaches	☐		Dizziness	☐		Sinus Problems	☐	
Neck pain/ stiffness	☐		Fainting	☐		Vision Problems	☐	
Shoulder pain/ stiffness	R ☐	L ☐	Fever	☐		GASTROINTESTINAL		
Arm/hand pain/ stiffness	R ☐	L ☐	Forgetfulness	☐		Constipation	☐	
Hip pain/ stiffness	R ☐	L ☐	Headaches	☐		Diarrhea	☐	
Leg/ foot pain/ stiffness	R ☐	L ☐	Loss of Sleep	☐		Excessive Hunger	☐	
Upper back pain/ stiffness	☐		Nervousness	☐		Excessive Thirst	☐	
Lower back pain/ stiffness	☐		Numbness	☐		Gas	☐	
High Blood Pressure	☐		Sweats	☐		Hemorrhoids	☐	
Diabetes	☐		EYES, EARS, NOSE			Other info not listed	☐	
TMJ (Jaw Problems)	☐		Ear Discharge	☐		_____		
Stomach/Intestinal Problems	☐		Earache	☐		_____		
Lung Problems	☐		Loss of Hearing	☐		_____		
Communicable Diseases	☐		Ringing in Ears	☐				
Bloating	☐		Bleeding Gums	☐				
Menstrual Problems	☐		Difficulty Swallowing	☐				
Pregnancy	☐		Blurred Vision	☐				
Prostate Problems	☐		Double Vision	☐				
Chronic Pain Syndrome	☐		Crossed Eyes	☐				
Memory Loss	☐		Persistent Cough	☐				
Bowel/Bladder Problems	☐		Hoarseness	☐				
Chills	☐		Hay Fever	☐				
Depression	☐		Nose Bleed	☐				

Tobacco ☐ Yes ☐ No

How often? _____

Alcohol ☐ Yes ☐ No

How often? _____

Caffeinated Beverages? ☐ Yes ☐ No

How often? _____

Recreational Drugs? ☐ Yes ☐ No

If yes, please discuss with doctor.

PATIENT NAME:

The patient or legal guardian must sign authorizations, such as in the case of a minor or when the patient is physically or mentally incompetent to sign. If patient is able to sign by marking an X, legal guardian must witness signature.

CONSENT FOR TREATMENT:

The signature below authorizes consent to have your picture taken for the sole purpose of identification. This material will not be sold or distributed for any reason.
The information I have provided is complete and true to the best of my knowledge. I authorize the doctors and staff of Allegheny Medical, P.C. to administer such procedures and treatment as deemed necessary, or as required by my employer. There is no written, verbal, or implied guaranteed cure on our part.
Due to our commitment to quality healthcare, we strive to improve services to our patients and we ask your consent prior to rendering treatment or services.

Signature of Patient _____ Date: _____

Signature of Guardian_____ Date: _____

ASSIGNMENT OF BENEFITS:

I _____ authorize Allegheny Medical, P.C. to be paid directly for services rendered. I accept responsibility for any service(s) that may not be covered by my health insurance, automobile insurance, or workers compensation carrier. I further authorize Allegheny Medical, P.C. to furnish information concerning my present illness or injury which may contact alcohol, drug, HIV or psychiatric related history to the insurer and health care providers involved in my care. I further direct the insurer to pay without equivocation directly to Allegheny Medical, P.C. any and all benefits due as a result of treatment and service(s) provided. I am aware that I am personally responsible for charges and/or balances not covered by my insurance carrier.
I hereby state and agree that a photocopy of this document will be deemed as valid and bindings on all parties involved as the original copy.

Signature of Patient _____ Date: _____

Signature of Guardian_____ Date: _____

PATIENT NAME:

MEDICARE ASSIGNMENT OF BENEFITS:

In accordance with the Medicare Act, Section 1842 (I) this letter is to advise you that Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862 (a) (II) (A) of the Medicare act. If Medicare determines that a particular service(s), although normally covered is not reasonable and necessary because the service(s) is maintenance in nature as defined by Medicare policy, Medicare will deny payment for those service(s). In your case, Medicare is likely to deny payment for the service(s) for lack of medical necessity. By my signature, I acknowledge notification by Allegheny Medical, P.C. that in my case, Medicare is likely to deny payment for those service(s).

If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signature of Patient _____ Date:_____

Signature of Guardian_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY:

PRACTICES FOR PROTECTED HEALTH INFORMATION

◯ I acknowledge that I have received and read "Notice of Privacy Practices" from Allegheny Medical, P.C.

_____	_____	_____
DATE	PRINT NAME OF PATIENT	SIGNATURE OF PATIENT/PERSONAL RESPRESENTATIVE

◯ I decline to read or accept a copy of the "Notice of Privacy Practices" from Allegheny Medical, P.C.

_____	_____	_____
DATE	PRINT NAME OF PATIENT	SIGNATURE OF PATIENT/PERSONAL RESPRESENTATIVE

Missed Appointment and Cancellation Policy

Our goal is to provide quality individualized care in a timely manner to each of our patients. No-shows, late arrivals, and cancellations inconvenience those individuals who need access to our care. We would like to review with you our policy regarding missed appointments.

CANCELLATION OF AN APPOINTMENT/ MISSED APPOINTMENT (No shows)

Appointments are in high demand. If you need to reschedule an appointment for any reason we require 48 hour notice. This policy enables us to better utilize available appointments for patients in need of medical care. A cancellation is considered late when the appointment is cancelled without 48 hour advanced notice.

MISSED APPOINTMENTS (NO SHOWS)

We will charge a $50 missed appointment fee if we do not receive a 48 hour notice of cancellation.

If a second appointment is missed we will charge the cost of services that would have been incurred at the time of the appointment.

If a third appointment is missed within a year, and no appointment is rescheduled, the patient will be dismissed from the practice.

LATE ARRIVALS

Patients arriving 15 minutes or later for an appointment will be asked to reschedule the appointment for another day. If possible, an attempt will be made to reschedule the same day in the next open appointment slot. This appointment may be brief in nature due to the need to work you in between other scheduled patients.

I have read and understand the Missed Appointment, No Show, Late Arrival, and Cancellation Policy of Allegheny Medical and I agree to its terms.

_____ Date:_____

Patient Signature

_____ Date:_____

AM Staff Signature (witness)

ALLEGHENY MEDICAL
COMPLETE CARE. ONE PLACE.

Narcotic Prescription Policy

- **Each prescription will be written for a 30-day supply.**
- **Patient will need to be seen every 90 days; preferably, but not necessarily, by the provider initially prescribing the medication or more frequently as determined by the provider.**
- **Narcotic prescriptions need to be picked up at the office. The patient must do so themselves unless other arrangements are made previously and approved by the practice. A photo ID must be presented by anyone picking up the prescription. If someone other than the patient is picking up the prescription, the person picking up the prescription must be listen on the patient's HIPAA release of information form and in the patient's electronic medical record.**
- **Patient needs to use the same pharmacy all the time.**
- **If we find that the patient is obtaining narcotics from another provider, we will terminate our relationship immediately unless the medication is related to a post-surgical procedure.**
- **Patients are responsible for the controlled substance prescription given to them. If prescriptions are misplaced, stolen, lost or if the medication "runs out early," the medication will not be replaced under any circumstance.**
- **Patients will be subject to random urine drug screening to verify that medications are being taken as prescribed. This will be at the provider's request. Urine drug screens cannot be billed to insurance and will be charged to the patient. Failure to comply will result in discontinuation of the medication and possible discharge from care.**

Thank you for your cooperation in this matter.

I have read and understand my responsibilities as outlined above. I acknowledge the receipt of the notice of the narcotic policy.

Patient Signature: _____ DOB: _____

Print Name: _____ Date: _____