WORK COMP REGISTRATION

Today's Date_____

PATIENT REGISTRATION FORM

Social Security # _____-_____-_____ Patient Name:_____

Date of Birth:_____/_____/_____ Sex: _____Female _____Male

Address:_____ Apt #:_____ City:_____State:_____ Zip_____

Home phone:_____ * Cell phone:_____

Work Phone_____ Email Address:_____

INJURY:_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow

Race (check one): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other_____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino **Language:**_____

Name of Employer:_____ **Job Title/Department**:_____

Employer Address:_____ Employment Status: ___Full Time ___Part Time ___Self

Supervisor:_____ Best way to contact your Supervisor? ☐phone ☐☐fax ☐email

Supervisor ph:_____ **Fax**_____ **Email**_____

Human Resources contact info:_____

How did injury occur? (Briefly describe):_____

_____

_____

DATE OF INJURY/ONSET:_____ **TIME OF INJURY**:_____ **Address where you were injured:**

_____

_____

How did you hear about us?

- Insurance Company
- Referral by Doctor
- Employer
- Friend / Family
- PVMedCenter.com website
- Returning patient
- Other:_____

PLAYA VISTA MEDICAL CENTER
PATIENT INFORMATION

Welcome to Playa Vista Medical Center. To better serve you, please be as complete as possible.

NAME: _____

MAIN PROBLEM (5 words or less): _____

PAST MEDICAL PROBLEMS (check if you have had):

___migraine headaches	___tuberculosis (TB)	___elevated cholesterol	___kidney/bladder problems
___blood transfusion	___seizures	___lung problems	___elevated triglycerides
___stomach ulcers	___blood clots	___diabetes	___high blood pressure
___heart problems	___blood from rectum	___leg swelling	___other problems_____

_____

__surgery (please list operations and year done):_____

_____

_____

___Been pregnant? How many times?_____ How many children?_____ Date of last period._____

PLEASE LIST YOUR MEDICATIONS (frequency of use and dosage): _____

_____

_____

PLEASE LIST YOUR ALLERGIES TO MEDICATIONS (and what kind of allergic reaction you have): _____

_____

_____

PUT A CHECK IF YOU:

___smoke cigarettes	How many a day?_____	How many years?_____
___drink alcohol	How many a week?_____	How many years?_____
___use any non-prescription drugs?		

LIVING SITUATION: ___alone ___with spouse ___with family ___other

What is/was your occupation?_____Retired?_____

PUT A CHECK IF THERE IS A FAMILY HISTORY OF:

___strokes	___high blood pressure	___heart disease	___stomach problems	___cancer
___asthma	___emphysema	___diabetes	___kidney problem	___psychiatric problems

__parents alive

__mother deceased	Cause?_____	Age:_____
__father deceased	Cause?_____	Age:_____

PUT A CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING IN THE LAST 24 HOURS:

___fever	___eye problems	___nausea	___fast heart beat	___leg swelling
___sore throat	___ear problems	___vomiting	___urinary problems	___headache
___cough	___irregular heartbeat	___diarrhea	___abdominal pain	___weakness
___difficulty breathing	___chest pain	___shortness of breath	___pain with urinating	___wheezing

___Are there any questions you would like to discuss with the physician in private?

_____

PLAYA VISTA MEDICAL CENTER

SAFE ENVIRONMENT FOR PATIENT CARE: Weapons or other dangerous objects, illegal drugs and drugs not prescribed by the patient's physician are not permitted in the patient treatment area. The medical center's obligation to provide a safe environment for patient care must override the patient's right to privacy. The medical center reserves the right to search the patient treatment area and to confiscate such objects upon reasonable probable cause.

FINANCIAL AGREEMENT: The undersigned agrees whether he/she signs as agent or patient, that in consideration of the services to be rendered to the patient, he/she here by individually obligates himself/herself to pay the account of the medical clinic in accordance with the regular rates and terms of the medical clinic and or as set forth by the terms of managed care contracts entered into by medical center, and/or applicable Workers' Compensation regulation. Should the account be referred to an attorney for collection, the undersigned shall pay actual attorney's fees and collection expense. All delinquent account shall bear interest at the legal rate.

RELEASE OF INFORMATION: To the extent necessary to determine liability for payment and to obtain reimbursement, the medical clinic or attending physician may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of the hospital's charge, including but not limited to, insurance companies, health care services plan, or worker's compensation carriers. (Special permission is needed to release this information where the patient is being treated for alcohol or drug abuse.)

ASSIGNMENT OF INSURANCE BENEFITS: The undersigned authorizes, whether he/she as agent or patient, direct payment to the medical clinic or physicians, medical groups, and practitioners of any insurance benefits otherwise payable to the undersigned for his/her services at the rate not to exceed medical clinic regular charges. It is agreed that payment to the clinic, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

MEDICARE INSURANCE BENEFITS AND EXCLUSIONS: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers and information needed for this or a related medical claim. I request that payment of authorized benefits be made on my behalf. Some services may not be covered by Medicare, such as the following: 1) Worker's Compensation 2) dental 3) cosmetic surgery 4) custodial care 5) personal comfort items, and any service determined to be unnecessary or unreasonable by Medicare. The undersigned understand that the Department of Health and Human Services Health Care and Financing Administration requires that the patient's signature be released Medicare/Medi-Cal eligibility information. The undersigned authorizes the Social Security Administration to release the following information to medical health center.

PATIENT ENROLLED IN MANAGED CARE HEALTH PLAN: I understand that I am responsible for guarantee of my eligibility and obtaining approval for services from my HMO/PPO plan. Or I must plan for payment of services rendered at this time. I agree to be financially responsible for any and all charges for the visit if not covered by my health plan.

HEALTH CARE SERVICES PLANS: This clinic maintains a list of health care services plan with which it has contracted. A list of such plans is available upon request from the financial office. The medical clinic has no contract, express or implied, with any plan that does not appear on the list. The undersigned agrees that he/she is individually obligated to pay the full cost of all services rendered to him/her by the clinic if he/she belongs to a plan which does not appear on the above mentioned list.

MEDICAL AND SURGICAL CONSENT: The patient is in the care and supervision of his/her attending physicians and it is the responsibility of the medical clinic and its staff to carry out the instructions of such physician. The undersigned hereby consents to x-ray examinations, laboratory procedures, emergency treatment, medical or surgical treatments or medical clinic services rendered to the patient under general and special instructions of the physician.

NOTICE OF PRIVACY PRACTICE: The privacy practice notice is posted in Playa Vista Medical Center. I have read and understand how my health information may be used and disclosed. If I have questions or concerns I may request a copy of the Notice of Privacy Practice from Playa Vista Medical Center.

CLAIMS PROCESSING: We have verified your eligibility on-line. In order for us to see you today, we will need to collect $_____. Once the insurance processes your claim, you will receive an explanation of benefits notifying you of the final amount you are responsible for. If we have under collected, we will balance bill you, if we have over collected, we will send you a refund after the first of next month. WORK COMP *INITIAL HERE*

The undersigned certifies that he/she has read the foregoing, receiving a copy thereof, and is the patient, or is duty authorized by the patient as patient's general agent to execute the above and accept its terms.

SIGN HERE

_____ _____

Signature of Patient or Responsible party Date

_____ _____

Signature of Witness Date

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____a.m. _____p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
   _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
   _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* _____
10. Address. *Dirección.* _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.*
    _____
15. Insurance Policy Number. *El número de la póliza de Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

❑ Employer copy/*Copia del Empleador* ❑ Employee copy/ *Copia del Empleado* ❑ Claims Administrator/*Administrador de Reclamos* ❑ Temporary Receipt/*Recibo del Empleado*