CHAMBERS MEDICAL GROUP

CHAMBERS MEDICAL GROUP
FLORENCE CLINIC

51 CAVALIER BLVD., SUITE 240
FLORENCE, KENTUCKY 41042
PH (859) 525-6500
FAX (859) 525-6501

# PATIENT INTAKE FORM - PLEASE PRINT

## PERSONAL INFORMATION

NAME _____ EMAIL _____
FIRST MIDDLE - MAIDEN LAST

DATE OF BIRTH _____ GENDER _____ MARITAL STATUS _____
MONTH / DAY / YEAR SINGLE / MARRIED / DIVORCED

MAILING ADDRESS _____
NUMBER & STREET CITY STATE ZIP

PHONE _____ ALT PHONE _____ SOCIAL SECURITY NO. _____

Our practice uses text messages to communicate with our patients. You will receive a text message from 313-131. We will use text messaging to communicate your next appointment date and office closures. We will never disclose medical information via text message. By providing your cell phone number and signature, you agree to receive text messages from Chambers Medical Group. *Data plan charges may apply*:

CELL PHONE NO. _____ PATIENT SIGNATURE _____

## EMPLOYER INFORMATION

COMPANY NAME _____ OCCUPATION _____

ADDRESS _____
NUMBER & STREET CITY STATE ZIP

PHONE _____

## SPOUSE INFORMATION - EMERGENCY CONTACT

NAME _____
FIRST MIDDLE MAIDEN LAST

RELATIONSHIP _____ OCCUPATION _____

PHONE _____ ALT PHONE _____

## RELEASE OF MEDICAL RECORDS

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.

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 _____
MONTH / DAY / YEAR

PHYSICIAN NAME _____ PHONE _____

ATTORNEY NAME _____ PHONE _____

I further authorize information to be released to my ☐ Physician ☐ Attorney as indicated above.*
*Please select one or both – Physician / Attorney.

PATIENT SIGNATURE _____ DATE _____
MONTH / DAY / YEAR

## ACCIDENT INFORMATION

PATIENT NAME _____
FIRST MIDDLE MAIDEN LAST

DATE OF ACCIDENT _____ ☐ DRIVER OR ☐ PASSENGER
MONTH / DAY / YEAR

NAME OF CAR OWNER ☐ PATIENT OR ☐ OTHER _____ RELATIONSHIP _____
FIRST LAST

TYPE OF ACCIDENT ☐ AUTO ☐ BUS ☐ RENTAL CAR ☐ WORKERS COMP ☐ FALL ☐ OTHER _____

## AUTO INSURANCE INFORMATION

NAME OF INSURED _____
FIRST MIDDLE MAIDEN LAST

EFFECTIVE DATE _____ RELATIONSHIP TO INSURED _____
MONTH / DAY / YEAR

NAME OF AUTO INSURANCE COMPANY _____

ADDRESS _____ PHONE _____
NUMBER & STREET CITY STATE ZIP

HAS ACCIDENT BEEN REPORTED ☐ YES ☐ NO CLAIM NO. _____ POLICY NO. _____

**FOR OFFICE USE ONLY**

ADJ _____ COVERAGE INFO _____

DEDUCTIBLE _____ DEDUCTIBLE MET - ☐ YES ☐ NO COVERAGE - ☐ 80 ☐ 100 MEDPAY - ☐ YES ☐ NO

## HEALTH INSURANCE INFORMATION

NAME OF INSURED _____
FIRST MIDDLE MAIDEN LAST

PATIENT I.D. NO. _____ D.O.B. OF INSURED _____ GROUP NO. _____
MONTH / DAY / YEAR

EFFECTIVE DATE _____ RELATIONSHIP TO INSURED _____
MONTH / DAY / YEAR

EMPLOYER NAME _____

NAME OF HEALTH INSURANCE COMPANY _____

ADDRESS _____ PHONE _____
NUMBER & STREET CITY STATE ZIP

**FOR OFFICE USE ONLY**

DED _____ MET - ☐ YES ☐ NO COVERAGE _____ OUT OF NETWORK BENEFITS - ☐ YES ☐ NO

## WORKERS COMPENSATION INFORMATION

EMPLOYER'S NAME _____ PHONE _____

WORKERS COMP. CARRIER _____ FAX _____

ADDRESS _____ ADJUSTER _____
NUMBER & STREET CITY STATE ZIP

**FOR OFFICE USE ONLY**

DOCTOR _____ INFORMATION TAKEN BY _____

DIAGNOSIS CODES _____

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# AUTHORIZATION FOR RELEASE OF RECORDS

## RELEASE

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 _____ SOCIAL SECURITY NO. _____
FIRST LAST

I HEREBY AUTHORIZE _____
DOCTOR, OFFICE, OR INSTITUTION

TO RELEASE A COPY OF MY PROTECTED HEALTH INFORMATION TO CHAMBERS MEDICAL GROUP - 51 CAVALIER BLVD., SUITE 240 FLORENCE, KY 41042

## SPECIFIC DESCRIPTION OF INFORMATION

☐ ALL MEDICAL RECORDS
☐ NARRITIVE REPORTS
☐ EMERGENCEY ROOM RECORDS
☐ X-RAY REPORTS
☐ X-RAY FILMS
☐ HOSPITAL INPATIENT RECORDS
☐ MRI REPORTS
☐ MRI FILMS
☐ CT REPORTS
☐ PHYSICAL THERAPY RECORDS
☐ NERVE CONDUCTION / EMG STUDIES
☐ OTHER:

FROM DATES _____ TO _____
MONTH / DAY / YEAR MONTH / DAY / YEAR

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

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.

   PATIENT INITIALS _____

## PATIENT REPRESENTATIVE

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

I. I understand that this authorization will expire on _____ PATIENT INITIALS _____
MONTH / DAY / YEAR

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. PATIENT INITIALS _____

SIGNATURE OF PATIENT/ PATIENT REPRESENTATIVE _____ DATE _____
MONTH / DAY / YEAR

NAME OF PATIENT REPRESENTATIVE _____ RELATIONSHIP _____

Form must be completed before signing. You may refuse to sign this authorization

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# PATIENT QUESTIONNAIRE

## PATIENT DETAILS

Patient Name _____ Age _____ Date _____
MONTH / DAY / YEAR

Accident/Injury Type ☐ Auto ☐ Slip/Fall ☐ On the Job ☐ Other: _____

Date of Accident/Injury _____ Location _____
MONTH / DAY / YEAR

Were you wearing a seatbelt? ☐ Yes ☐ No You were the ☐ Driver ☐ Passenger - ☐ Front seat ☐ Back seat

In your own words, please describe the accident/injury

_____

Were you struck in the ☐ Front ☐ Rear ☐ Driver's side ☐ Passenger's side

Were you knocked unconscious? ☐ Yes ☐ No If yes for how long? _____

Were you examined by paramedics, EMT or any other first responder after the accident? ☐ Yes ☐ No

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

Drivin to the Hospital by ☐ Ambulance ☐ Self ☐ Other _____

Were X-Rays taken? ☐ Yes ☐ No

Were you given medication? ☐ Yes ☐ No

Were you told the diagnosis? ☐ Yes ☐ No If yes please describe

_____

Have you been treated since the accident? ☐ Yes ☐ No If yes please include doctor's name, address, and treatment below

Name _____ Address _____
NUMBER & STREET CITY STATE ZIP

Describe treatment _____

Have you ever had similar symptoms prior to the accident/injury? ☐ Yes ☐ No If yes please describe

_____

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

_____

Have you ever had any surgeries? ☐ Yes ☐ No If yes please describe _____

Do you have any surgical implants ☐ Yes ☐ No If yes please describe _____

Do you have any health problems we need to know about (including any allergies to medications)? ☐ Yes ☐ No If yes please describe

_____

List any allergies _____

List any current medications _____

Are you pregnant? ☐ Yes ☐ No If yes, expected due date _____

Have you lost time from work as a result of this accident? ☐ Yes ☐ No If yes please complete details below

Dates missed _____ through _____ Type of work _____
MONTH / DAY / YEAR MONTH / DAY / YEAR

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

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# PATIENT INJURY IDENTIFICATION

## SELECT ALL SYMPTOMS THAT APPEARED AS A RESULT OF YOUR ACCIDENT/INJURY

MENTAL HEALTH: ☐ ANXIOUS / NERVOUS TO DRIVE / RIDE IN A CAR ☐ PANIC ATTACKS / ANXIETY ☐ NIGHTMARES ☐ DEPRESSION
☐ IRRITABLE ☐ FATIGUE ☐ FORGETFULNESS ☐ WEIGHT GAIN ☐ WEIGHT LOSS
DIFFICULTY: ☐ CONCENTRATING ☐ READING ☐ WRITING ☐ SLEEPING
MEMORY LOSS: ☐ SHORT TERM ☐ LONG TERM ☐ BOTH

---

HEAD: ☐ RINGING IN EARS ☐ BLURRED VISION ☐ DIZZINESS
☐ LOSS OF BALANCE ☐ LOSS OF COORDINATION
☐ LACK OF BALANCE OR DIZZINESS WHEN TURNING HEAD
☐ PAIN WHEN CHEWING ☐ CLICKING SENSATION WHEN CHEWING

---

NECK: ☐ PAIN ☐ STIFFNESS ☐ HEAVINESS ☐ POPPING OR CRUNCHING SENSATION

---

UPPER BODY: LOSS OF RANGE OF MOTION IN SHOULDERS: ☐ LEFT ☐ RIGHT ☐ BOTH
PAIN WHEN MOVING SHOULDERS: ☐ LEFT ☐ RIGHT ☐ BOTH
NUMBNESS/TINGLING DOWN ARM: ☐ LEFT ☐ RIGHT ☐ BOTH
ELBOW PAIN: ☐ LEFT ☐ RIGHT ☐ BOTH
WRIST PAIN: ☐ LEFT ☐ RIGHT ☐ BOTH
NUMBNESS/TINGLING IN HAND: ☐ LEFT ☐ RIGHT ☐ BOTH
WEAKNESS IN HAND: ☐ LEFT ☐ RIGHT ☐ BOTH

---

BACK: BACK PAIN FROM PROLONGED PERIOD OF TIME: ☐ SITTING ☐ STANDING
☐ TROUBLE BENDING OVER ☐ TROUBLE GETTING STRAIGHT AGAIN AFTER BENDING OVER

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LOWER BODY: HIP PAIN: ☐ LEFT ☐ RIGHT ☐ BOTH
PAIN GOING INTO THE BUTTOCKS: ☐ LEFT ☐ RIGHT ☐ BOTH
GOING DOWN THE LEGS: ☐ PAIN ☐ NUMBNESS ☐ LEFT ☐ RIGHT ☐ BOTH
PAIN/ NUMBNESS GOING DOWN THE LEGS TRAVELS INTO: ☐ CALF ☐ FOOT
KNEE PAIN: ☐ LEFT ☐ RIGHT ☐ BOTH
ANKLE PAIN: ☐ LEFT ☐ RIGHT ☐ BOTH

---

OTHER: ☐ BRUISING FROM THE SEATBELT – LOCATION OF BRUISING: _____

LIST ANY OTHER CUTS, BRUISES, OR ABRASIONS FROM THE ACCIDENT:

_____

☐ OTHER SYMPTOMS/PROBLEMS NOT LISTED:

_____

☐ ANY PREVIOUS INJURIES/SURGERIES THAT HAVE BEEN RESOLVED, BUT NOW HAVE BEEN MADE WORSE SINCE THE ACCIDENT:

_____

_____

_____

_____

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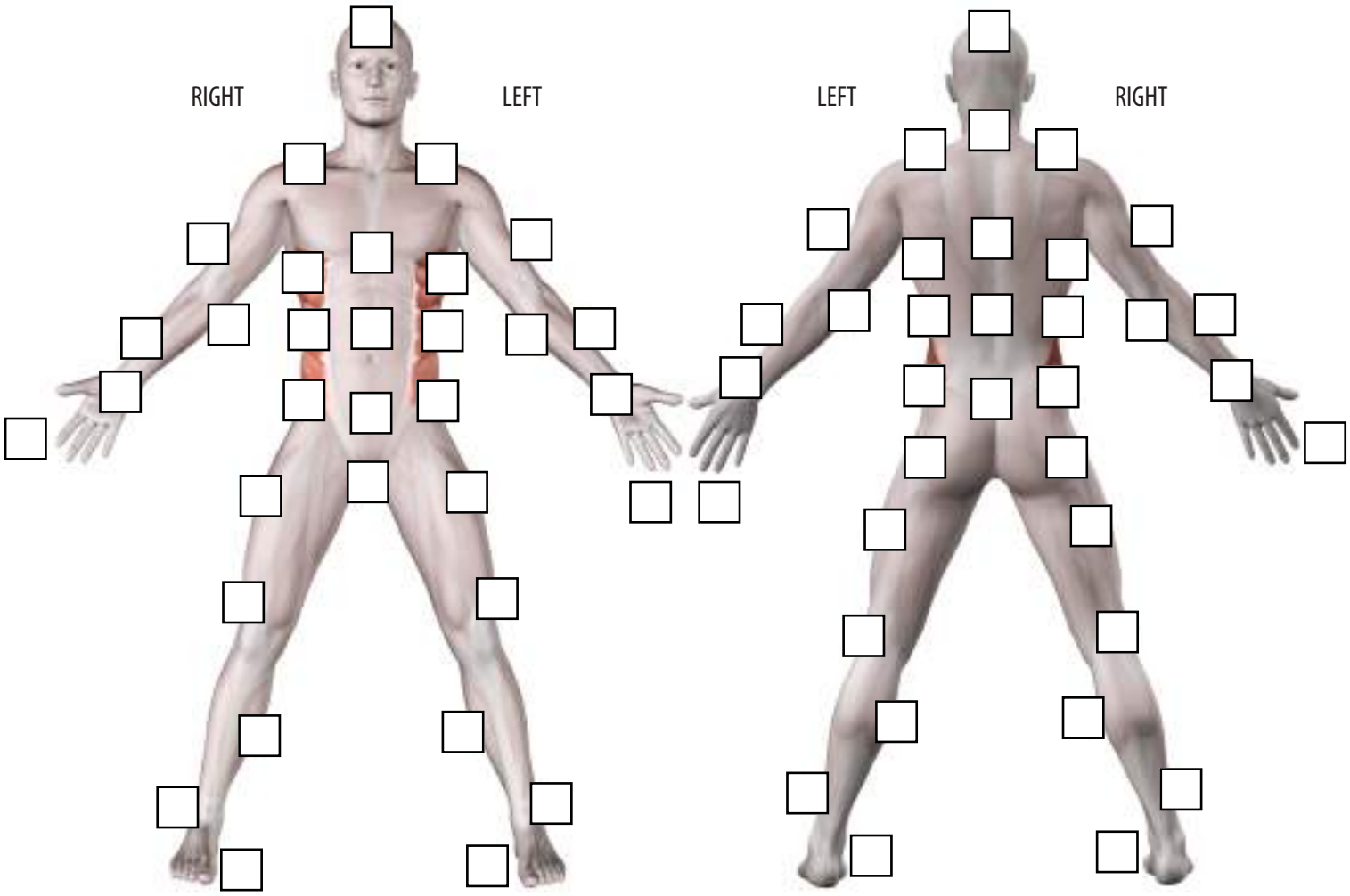
# PATIENT INJURY IDENTIFICATION

## DIAGRAM OF INJURIES

Draw or shade in the location of your body injuries that are as a result of your most recent accident. 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, and back and include notes about pain during activities such as lifting, bending and working. This is very important so the physician doesn't overlook any injuries.



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# INFORMED CONSENT TO TREATMENT

## RELEASE

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 SIGNATURE _____ DATE _____
MONTH / DAY / YEAR

WITNESS SIGNATURE _____

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# ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

## INSURER AND PATIENT PLEASE READ THE FOLLOWING IN ITS ENTIRETY CAREFULLY

I, the undersigned patient/Insured knowingly, voluntarily and intentionally assign the rights and benefits of my Automobile Insurance, also known as Personal Injury Protection (hereinafter PIP), Uninsured Motorist and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the Insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the Insurer disputes the validity of this assignment of benefits then the Insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the Insurer to contest the validity of this document. The undersigned directs the Insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP Insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled. I as the named Insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP Insurance to this provider and to file suit for recovery of the premiums. The Insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named Insured a check which represents the difference between the medical bills and the premiums paid.

**DISPUTES:** The Insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the Insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the Insurer as to the amount payable under the insurance policy. The Insured and provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the Insurer and deposited by the provider shall be done so under protest, at the risk of the Insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The Insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP Insurer states it can pay claims at 200% of Medicare then the Insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. Any effort by the Insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager and mailed to the attention of the Office Manager. See Fla. Stat. §673.3111.

**EUOS AND IMES:** If the Insurer schedules a defense examination or examination under oath (hereinafter "EUO") the Insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the Insurer. The health care provider is not the agent of the Insurer or the patient for any purpose. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider, and to request and obtain a copy of any statements or examinations under oath given by patient.

**RELEASE OF INFORMATION:** I hereby authorize this provider to: furnish an Insurer, an Insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the Insurer; request from any Insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets: obtain any written and verbal statements the patient or anyone else provided to the Insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents. reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The Insurer is directed to keep the patient's medical records from this provider private and confidential. The Insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

**DEMAND:** Demand is hereby made for the Insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The Insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the Insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the Insurer on the same day then the Insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the Insurer for any reason, or amount, the Insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The Insurer is instructed to inform, in writing, the provider of any dispute.

**CERTIFICATION:** I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; I agree the provider's prices for medical services, treatment and supplies are reasonable and customary.

**CAUTION:** Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

PATIENT NAME (PLEASE PRINT) _____ DATE _____
MONTH / DAY / YEAR

PATIENT'S SIGNATURE _____
(IF PATIENT IS A MINOR, SIGNATURE OF PARENT/GUARDIAN)

# 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.

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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 YOU 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 YOU 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

**IMPORTANT:** CHOOSE ONE OF THE REIMBURSEMENT METHODS LISTED BELOW.

☐ PLEASE PAY ME DIRECTLY ☐ PLEASE PAY MY MEDICAL PROVIDER DIRECTLY

**IF WE PAY YOU DIRECTLY, YOU WILL BE RESPONSIBLE FOR PAYING YOUR MEDICAL PROVIDERS PROMPTLY, IF YOU FAIL TO PAY YOUR MEDICAL PROVIDERS PROMPTLY, COLLECTION PROCEEDINGS AND INTEREST CHARGES MAY BE BROUGHT AGAINST YOU.**

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YOU MAY DIRECT THE PAYMENT OF PERSONAL INJURY PROTECTION COVERAGE TO THE DIFFERENT COVERED EXPENSES (WAGE LOSS, REPLACEMENT SERVICES, AND/OR MEDICAL EXPENSES) UNDER PIP ON A PROSPECTIVE BASIS. PLEASE DESCRIBE, IN WRITING, HOW YOU WOULD LIKE YOU PERSONAL INJURY PROTECTION BENEFITS TO BE DISTRIBUTED AMONG THE DIFFERENT COVERED EXPENSES UNDER PIP.

_____

_____

IF YOU DO NOT DESCRIBE, IN WRITING, HOW YOU WOULD LIKE YOUR PERSONAL INJURY PROTECTION BENEFITS TO BE DISTRIBUTED, THEN BENEFITS WILL BE PAID ON A MONTHLY BASIS AS YOU INCUR MEDICAL EXPENSES, WAGE LOSS, AND/OR REPLACEMENT SERVICES LOSS.

NOTE THAT THE MAXIMUM AMOUNT WE WILL PAY FOR WAGE LOSS OR REPLACEMENT SERVICES IN ANY ONE WEEK IS $200.

---

**-DO NOT DETACH-**

IF YOU ARE CLAIMING MEDICAL EXPENSES, PLEASE SIGN THE FOLLOWING:

**AUTHORIZATION FOR MEDICAL INFORMATION**

**This authorization or photocopy hereof will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-ray and physical findings, diagnosis and prognosis. You are authorized to provide this information in accordance with the Personal Injury Protection Benefits (Kentucky No-Fault) Law.**

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**Signature** **Date**

IF YOU ARE CLAIMING LOST WAGES, PLEASE SIGN THE FOLLOWING:

**AUTHORIZATION FOR WAGE AND SALARY INFORMATION**

**This authorization or photocopy hereof will authorize you to furnish all information you may have regarding my wages or salary while employed by you. You are authorized to provide this information in accordance with Personal Injury Protection Benefits (Kentucky No-Fault) Law.**

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**Signature** **Date**

**Social Security No. _____**