



North Texas Clinic and Rehabilitation Center

729 W Bedford Euless Rd, STE 204

Hurst, TX 76053

P: 817.952.3160

F: 817.952.3161

WORKERS COMP INTAKE

Patient Information

Legal Name: (Last) _____ (First) _____ (MI) _____ Birth Date: _____

Biological Sex: ☐ Male ☐ Female ☐ Intersex Pronouns: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown Race: _____

Email: _____ Primary Phone: _____ ☐ Home ☐ Cell ☐ Work

Address: _____ City: _____

State: _____ Zip: _____ ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

Social Security #: _____ Patient Employer: _____

Occupation: _____ Address: _____ Phone: _____

In case of emergency, contact: _____ Relationship: _____ Phone: _____

Who is primary guardian/caretaker? _____ Relationship: _____ Phone: _____

How did you hear about our office? (Please select): Doctor/Health care provider: _____

☐ Insurance Portal ☐ Family ☐ Friend ☐ Online (Google, etc.) ☐ Close to home/work

Friend/Family/Current Patient (Name): _____ ☐ Other: _____

Payment/ Insurance Information

☐ Self-Pay ☐ Health Insurance ☐ Work Comp (WC) ☐ Personal Injury (PI)

Subscriber Name: _____

Birth Date: _____ Phone: _____ Relationship to Patient: _____

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

☐ Health Insurer Insurance Co. Name: _____ ID #: _____ Group #: _____

☐ Government Program Name: _____ ID #: _____

Is patient covered by additional/secondary insurance? ☐ Yes ☐ No

Insurance Co. Name: _____ ID #: _____ Group #: _____

Subscriber Name: _____ Birth Date: _____ Relationship to Patient: _____

Assignment and Release

On behalf of yourself and any patient whom you are the parent or legal guardian you 1 certify that the information on this form is accurate and up-to-date, 2) consent to treatment by NTXC&RC, 3) assign to NTXC&RC, any health care insurance or reimbursement benefits to which you are entitled for the care provided by NTXC&RC, authorize their payment directly to NTXC&RC, and authorize the use of your signature for this limited purpose, 4) agree to be primarily responsible for all charges owed to NTXC&RC (other than those included in any pre-paid offer), including attorney fees, court costs, and other expenses of collection, 5) consent to NTXC&RC releasing any "protected health information," as defined by federal HIPAA regulations, for the purposes allowed by law, and 6) acknowledge receipt of NTXC&RC's Notice of Privacy Practices.

Patient/Legal Guardian Name (Printed): _____ Date: _____

Patient/Legal Guardian Signature: _____ Relationship to Patient: _____

WORKERS COMP INTAKE

Date of Accident: _____ Time: _____ ☐ AM ☐ PM

Who was the injury reported to? _____

What was the location of the accident? _____

What state did the accident occur in? _____

Employer at time of the injury: _____ Hire Date: _____

Job Title and Job Description: _____

Describe duties: _____

Describe restrictions: _____

Describe the injury in detail: _____

Are you currently working? ☐ Yes ☐ No With Restrictions? ☐ Yes ☐ No

I am doing the same job duties as before the injury: ☐ Yes ☐ No

The last day I worked was: _____

Have you missed time from work? ☐ Yes ☐ No If yes, what days? _____

Has this type of accident happened to you before? ☐ Yes ☐ No If yes, when? _____

As a result of the accident, were you:

☐ Rendered unconscious ☐ In shock ☐ Dazed ☐ Other: _____

Were you wearing glasses? ☐ Yes ☐ No Could you move all parts of your body? ☐ Yes ☐ No

If no, what parts couldn't you move and why?

Were you able to walk unaided? ☐ Yes ☐ No

If no, why not? _____

Did you get bleeding cuts? ☐ Yes ☐ No If yes, where? _____

Did you get any bruises? ☐ Yes ☐ No If yes, where? _____

Describe how you felt: _____

Immediately after the accident: _____

Later that day: _____

The next day: _____

Now: _____

Please indicate the symptoms that are a result of this accident:

- | | | | |
|--|--|---|--|
| ☐ Dizziness | ☐ Depression | ☐ Jaw Pain | ☐ Nausea |
| ☐ Memory Loss | ☐ Irritability | ☐ Arms/Shoulder Pain | ☐ Blurred Vision |
| ☐ Headache(s) | ☐ Fatigue | ☐ Numbness/Tingling | ☐ Leg Pain |
| ☐ Ringing in Ears | ☐ Tension | ☐ Chest Pain | ☐ Back Stiffness |
| ☐ Neck pain | ☐ Shortness of Breath | ☐ Anxiety | ☐ Light Sensitivity |
| ☐ Facial Pain | ☐ Neck Stiffness | ☐ Loss of Balance | ☐ Muscle Spasms |
| ☐ Midback pain | ☐ Muscles Soreness | ☐ Back Pain | |
| ☐ Other: _____ | | | |

Have you been to any doctor and/or hospital as a result of the accident? ☐ Yes ☐ No

If yes, when you go? ☐ Immediately after the accident ☐ The next day ☐ +2 days

How did you get there? ☐ Ambulance ☐ Private transportation

Name of Hospital/Facility and attending doctor: _____

Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

Was MRI/CT taken? ☐ Yes ☐ No

Describe any treatment you received: _____

Is your condition: ☐ Improving ☐ Worsening ☐ Staying the same ☐ Comes and goes

Briefly describe the events that occurred just before and during your accident: _____

I, the undersigned, hereby agree that the above information is true and in no way fabricated. I understand that if any of my medical or account information has changed that I must inform the front desk personnel. Please remember you are ultimately responsible for your account.

Patient's and/or Legal Guardian's Signature: _____

Date: _____

Workers Compensation Claim Information

Workers Comp Company: _____ Agent Name: _____
Phone Number: _____ Fax Number: _____
Claim Number: _____ Date of Initial Injury: _____

Preferred Pharmacy

Pharmacy Name: _____ Phone Number: _____
Street Address: _____ City/State/Zip: _____

Please do not wait until your last pill to call for a refill. There is a 24-48 hour turn around for prescription refills. If you have not seen the physician in six (6) months, the prescription will be denied. If prescription is considered a *controlled substance*, you are required by law to be physically seen in office once every three (3) months for prescriptions to be authorized (more frequent visits may be requested at provider's discretion).

Primary Complaint

Use the pain scale described below to rate your pain for the questions below:

0 – Pain Free

1 – Very minor annoyance, occasional minor twinges

2 – Minor annoyance, occasional strong twinges

3 – Annoying enough to be distracting

4 – Can be ignored if you are really involved in work/task, but still distracting

5 – Cannot be ignored for more than 30 minutes

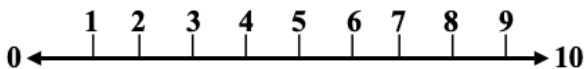
6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities

7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort

8 – Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness cause by pain.

9 – Unable to speak, crying out, or moaning uncontrollably, near delirium.

10 – Unconscious, pain makes you pass out



Reason for today's visit: _____

Please describe the condition: _____

When did your symptoms first appear?

☐ In the past few days ☐ In the last 30 days ☐ In the last year

☐ In the last 2 years ☐ In the last 5 years ☐ More than 5 years ago ☐ Date: _____

Since it began, how has the condition changed? ☐ Improving ☐ Worsening ☐ Staying the same

Rate the severity of your pain ...at its worst: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

(Please circle) ...at its least: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

...at present moment: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

How often do you have the pain? ☐ Constantly ☐ Comes and goes ☐ Infrequently ☐ Daily ☐ Weekly ☐ Monthly

When is your pain at its worst? ☐ Mornings ☐ During the day ☐ Evenings ☐ Middle of the night

Does the pain travel from one location to another? ☐ Yes ☐ No

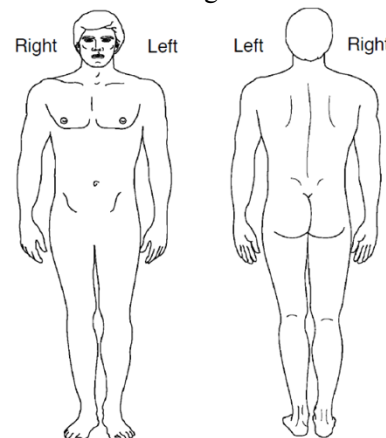
If yes, from where to where? _____

What make the condition worse? _____

What make the condition better? _____

Use the diagram to your right to indicate the location and type of pain you are experiencing. Mark the drawing with the following letters that best describe your symptoms:

- "N" = numbness
- "S" = stabbing
- "B" = burning
- "P" = pins and needles
- "A" = aching
- "T" = Throbbing



Past Medical History

Name of primary care doctor: _____ ☐ None ☐ Interested in establishing care

Date of Last: Physical Exam: _____ Blood Test: _____ Urine Test: _____

Menstrual Period (LMP): _____ Spinal X-ray: _____ MRI, CT-Scan, Bone Scan: _____

Please indicate whether you have experienced any of the following and complete information below:

- | | | | |
|--|--|--|---|
| ☐ NONE of the problems listed | ☐ Celiac Disease | ☐ Hepatitis | ☐ Pulmonary Embolism |
| ☐ AIDS/HIV | ☐ Chicken Pox | ☐ Hernia | ☐ Pinched Nerve |
| ☐ Allergies | ☐ Clotting Disorder | ☐ Herniated Disc | ☐ Pneumonia |
| ☐ Anxiety | ☐ Congestive Heart Failure | ☐ High Blood Pressure | ☐ Prostate Problems |
| ☐ Appendicitis | ☐ Depression | ☐ Kidney Disease | ☐ Psychiatric Care |
| ☐ Arterial Fibrillation | ☐ Diabetes | ☐ Liver Disease | ☐ Rheum. Arthritis |
| ☐ Arthritis Conditions | ☐ Drug/Alcohol Abuse | ☐ Migraines | ☐ STD/STI |
| ☐ Asthma | ☐ Eating Disorder | ☐ Mononucleosis | ☐ Stroke |
| ☐ Autoimmune Disorder | ☐ Emphysema | ☐ Multiple Sclerosis | ☐ Thyroid Disease |
| ☐ Bleeding Disorder | ☐ Epilepsy/Seizure Disorder | ☐ Organ Injury | ☐ Tuberculosis |
| ☐ Bronchitis | ☐ GERD | ☐ Osteoporosis | ☐ Tumors, Growths |
| ☐ Cancer | ☐ Headaches | ☐ Pacemaker | Other: _____ |
| ☐ Cardiac Arrest | ☐ Heart Disease | ☐ Parkinson's | |

Are you pregnant? ☐ Yes ☐ No If yes, how many weeks? _____ Name of OBGYN: _____

Please indicate if you have allergies to any of the following:

- | | | | | |
|---|--|-------------------------------------|-----------------------------------|-------------------------------------|
| ☐ NONE/ No known allergies | ☐ Adhesive Tape | ☐ Anesthesia | ☐ Aspirin | ☐ Codeine |
| ☐ Dairy Products | ☐ Iodine/Shellfish/Contrast | ☐ Latex | ☐ Morphine | ☐ Penicillin |
| ☐ Other: _____ | | | | |

Have you ever been allergy tested? ☐ Yes ☐ No **Are you interested in allergy testing?** ☐ Yes ☐ No

Have you ever... ..been hospitalized? ☐ Yes ☐ No **When and why?** _____

...had a fracture/dislocation? ☐ Yes ☐ No **When and why?** _____

...had any major illnesses? ☐ Yes ☐ No **When and why?** _____

Surgical History: Please indicate any surgical procedures you have had in the past (include date, type, and any pertinent details)

Abdominal Surgery

- ☐ Gallbladder Removal _____
- ☐ Appendectomy _____
- ☐ Other _____

Joint Surgery

- ☐ Shoulder _____
- ☐ Hip _____
- ☐ Knee _____

Spine/Back Surgery

- ☐ Discectomy (levels) _____
- ☐ Laminectomy _____
- ☐ Spinal Fusion (levels) _____

Heart Surgery

- ☐ Valve Replacement _____
- ☐ Aneurysm Repair _____
- ☐ Angioplasty _____
- ☐ Other _____

Female Surgeries

- ☐ Cesarean Section _____
- ☐ Hysterectomy _____
- ☐ Laparoscopy _____
- ☐ Ovarian _____
- ☐ Other _____

Other Common Surgeries

- ☐ Hernia Repair _____
- ☐ Thyroidectomy _____
- ☐ Hemorrhoid Surgery _____
- ☐ Tonsillectomy _____
- ☐ Vascular stent _____

Cosmetic/Surgery Type Not listed: _____

Medications and Supplements

Please list any medications, supplements, or over-the-counter substance you are currently taking:

PLEASE PRINT LEGIBLY – NO CURSIVE

[illegible]

Family Medical History

Please indicate if any of your relatives and which one has had any of the following conditions:

Specify maternal (mother's side) or paternal (father-side) for grandparents

☐ I HAVE NO SIGNIFICANT FAMILY HISTORY

☐ I AM ADOPTED (No Medical History Available)

<u>Arthritis</u>	☐ Mother	☐ Father	☐ Grandmother - _____	☐ Grandfather- _____
<u>Asthma</u>	☐ Mother	☐ Father	☐ Grandmother - _____	☐ Grandfather- _____
<u>Autoimmune Disease</u>	☐ Mother	☐ Father	☐ Grandmother - _____	☐ Grandfather- _____
<u>Cancer</u>	☐ Mother	☐ Father	☐ Grandmother - _____	☐ Grandfather- _____
<u>Connective Tissue Dis.</u>	☐ Mother	☐ Father	☐ Grandmother - _____	☐ Grandfather- _____
<u>Diabetes</u>	☐ Mother	☐ Father	☐ Grandmother - _____	☐ Grandfather- _____
<u>Heart Disease</u>	☐ Mother	☐ Father	☐ Grandmother - _____	☐ Grandfather- _____
<u>High Blood Pressure</u>	☐ Mother	☐ Father	☐ Grandmother - _____	☐ Grandfather- _____
<u>Kidney Disease</u>	☐ Mother	☐ Father	☐ Grandmother - _____	☐ Grandfather- _____
<u>Thyroid Disease</u>	☐ Mother	☐ Father	☐ Grandmother - _____	☐ Grandfather- _____
<u>Tuberculosis</u>	☐ Mother	☐ Father	☐ Grandmother - _____	☐ Grandfather- _____
<u>Bleeding Disorder</u>	☐ Mother	☐ Father	☐ Grandmother - _____	☐ Grandfather- _____
<u>Heart Attack</u>	☐ Mother	☐ Father	☐ Grandmother - _____	☐ Grandfather- _____
<u>Stroke</u>	☐ Mother	☐ Father	☐ Grandmother - _____	☐ Grandfather- _____
<u>Other Medical Problems:</u> _____				

Social History

Please briefly describe your current physical activities (e.g., walking, swimming, golfing, etc.)

Do you engage in an exercise program? ☐ Regularly ☐ Occasionally ☐ Rarely/Never

Can you perform your daily activities at home? ☐ Yes ☐ Yes, but only with help ☐ No

How many servings of fruits and vegetables do you eat each day? ☐ 0 ☐ < 1 ☐ 1-2 ☐ 3-4 ☐ 5-7 ☐ > 7

How many glasses of water do you drink a day? ☐ 0 ☐ < 1 ☐ 1-2 ☐ 3-4 ☐ 5-7 ☐ > 7

How many caffeinated beverages do you drink a day? ☐ 0 ☐ < 1 ☐ 1-2 ☐ 3-4 ☐ 5-7 ☐ > 7

How many sugary beverages do you drink a week? ☐ 0 ☐ < 1 ☐ 1-2 ☐ 3-4 ☐ 5-7 ☐ > 7

Alcohol Use: ☐ Never Drinks ☐ Drinks Daily ☐ Drinks Socially ☐ Current Alcoholism ☐ Recovering Alcoholic

How many alcoholic beverages do you drink a week? ☐ 0 ☐ < 1 ☐ 1-2 ☐ 3-4 ☐ 5-7 ☐ > 7

Do you use tobacco/smoke/vape products? ☐ Yes ☐ No Type: ☐ Cigarettes ___packs/day ☐ Chew ☐ Vaping ☐ Cigars

Are you sexually active? ☐ Yes ☐ No Are you interested in STD testing? ☐ Yes ☐ No

Illegal Drug Use: ☐ Denies Any Illegal Drug Use ☐ Currently Using Illegal Drugs (Type _____) ☐ Currently Uses Marijuana

☐ Currently Using Someone's Prescription Medications ☐ Formerly Used Illegal Drugs (not currently using) (Type: _____)

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No Which type? _____

Review of Systems

Please mark the following symptoms that you currently suffer from. (Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.)

Constitutional

- ☐ Fever
- ☐ Chills
- ☐ Loss of Appetite
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Unexplained Weight Loss
- ☐ Unexplained Weight Gain
- ☐ Other: _____

Musculoskeletal

- ☐ Back pain
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Spinal Infection
- ☐ Spinal Bone Tumors
- ☐ Unstable Fracture
- ☐ Limb Pain
- ☐ Other: _____

Neurological

- ☐ Sudden Numbness
- ☐ Headaches
- ☐ Loss of Sensation
- ☐ Confusion
- ☐ Dizziness
- ☐ Slurred Speech
- ☐ Loss of Balance
- ☐ Other: _____

Cardiovascular

- ☐ High Blood Pressure
- ☐ Lightheadedness/Fainting
- ☐ Chest Pain
- ☐ Swelling in Feet
- ☐ Deep Vein Thrombosis
- ☐ Patchy/Loss of hair on legs
- ☐ Irregular Heartbeat
- ☐ Other: _____

Respiratory

- ☐ Cough
- ☐ Common Cold
- ☐ Wheezing
- ☐ COPD
- ☐ Emphysema
- ☐ Shortness of Breath w/ Exertion
- ☐ Shortness of Breath at Rest
- ☐ Other: _____

Eyes

- ☐ Vision Trouble
- ☐ Double Vision
- ☐ Night Blindness
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Discharge
- ☐ Droopy Eyelids
- ☐ Other: _____

Ears, Nose, Throat, Mouth

- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Vertigo
- ☐ Nosebleeds
- ☐ Dry Mouth
- ☐ Change in Taste
- ☐ Bleeding Gums
- ☐ Other: _____

Skin

- ☐ Changes in Moles
- ☐ Rashes/Itching
- ☐ Discoloration
- ☐ Masses/Lumps
- ☐ Sores/Blisters
- ☐ Changes in hair or nails
- ☐ Excessive Dryness
- ☐ Other: _____

Gastrointestinal

- ☐ Diarrhea/Constipation
- ☐ Dark and Tarry Stools
- ☐ Loss of Bowel Control
- ☐ Acid Reflux
- ☐ Nausea/Vomiting/Heartburn
- ☐ Ground Coffee Vomit Appearance
- ☐ Abdominal Pain/Cramping
- ☐ Other: _____

Genitourinary

- ☐ Urine Color Change
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Leakage/Loss of Bladder Control
- ☐ Urgency
- ☐ Decreased Urine Flow/Frequency
- ☐ Prostate Problems
- ☐ Other: _____

Endocrine

- ☐ Excessive Thirst/Hunger
- ☐ Hot/Cold Intolerance
- ☐ Hot Flashes
- ☐ Low Sex Drive
- ☐ Insomnia
- ☐ Thinning/Loss of Hair
- ☐ Excessive Urination
- ☐ Other: _____

Psychiatric

- ☐ Depressed Mood
- ☐ Feeling Anxious
- ☐ Suicidal Thoughts
- ☐ Inability to Concentrate
- ☐ Mood Swings
- ☐ Memory Problems
- ☐ Hallucinations (sound or sight)
- ☐ Other: _____

Do you have any other concerns or questions you would like to be addressed by the practitioner?



North Texas Clinic and Rehabilitation Center

CONSENT TO TREAT

I agree to be treated by Russell Skinner, MD, Vaughn Brozek, DC, FNP-C, or _____ for the injury/condition I have consulted hem/her for. I consent and authorize testing and treatment as ordered by my doctor and/or their associates. I further authorize the provider's assistant(s) and staff to carry out their instructions with respect to the procedures and treatment ordered. I understand that the provider(s) will develop an individualized treatment plan for my care, and in order to recover in the shortest possible time this treatment plan must be followed.

I hereby further agree to maintain and cooperate with the above-named provider's recommendations for the care of this injury/condition. In the event of excessive missed appointments without notification or authorization of the above-named providers, it will be assumed that I have reach a point of stabilization and that I am dismissing myself from their care. In this event, I authorize the providers to notify my insurance carrier, legal representation, and/or employer that I am no longer being treated and I have released myself from care. I acknowledge that no guarantees or warranties have been made with me to respect to treatment to be provided at this office. I understand that all supplies, medical devices, and other goods sold or furnished to me by the clinic are sold or furnished on an "AS IS" basis and North Texas Family Care, PLLC disclaims any expressed or implied warranties with respect to them.

Patient Signature: _____ Date: _____

Patient Printed Name: _____

Legal Guardian/Representative if Under age eighteen (18): _____

Reviewed By: _____ Date: _____

North Texas Clinic and Rehabilitation Center

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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 of Privacy Practices before signing this consent.

The terms of the Notice of Privacy Practices may change. If this happens, you will be notified and asked at your next visit to review the changes and complete an updated HIPAA Compliance Consent Form.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or health care 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 health care operations.

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

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient 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 disclosure will cease upon receipt of the revocation.
- The practice may condition receipt of treatment upon execution of this consent.

May we contact you by phone, email, or text for appointment confirmations? ☐ Yes ☐ No

May we leave a message on your voicemail at home or on your cell phone? ☐ Yes ☐ No

May we discuss your medical condition(s) with a family member or authorized person? ☐ Yes ☐ No

If yes, please list below the name(s) and relationship(s) of any persons that we may discuss your medical condition(s) with:

Patient Name (Printed): _____ Date of Birth: _____

Patient/Legal Guardian Signature: _____ Date: _____



ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION AGREEMENT

I hereby direct any and all insurance carriers, attorneys, agencies, companies, individuals, and/or other legal entities ("payers") which may elect to be obligated to pay me for any reason, to pay directly to, and exclusively in the name of North Texas Family Care, PLLC ("NTXC&RC"), in the amount of the full charges incurred by me at NTXC&RC, past or future, including but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at NTXC&RC ("my charges"). I further grant a contractual lien to NTXC&RC with respect to my charges, however I understand that nothing in this agreement shall be construed as an election by NTXC&RC to claim protection under any statutory lien law. For the purposes of this Agreement, proceeds shall include, but shall not be limited to, proceeds from any settlement, judgement, or verdict, as well as proceeds relating to the following: insurance coverage, lost wage benefits, lost health, disability, worker's compensation, medical payment benefits, personal injury protection, lost wage benefits, lost services, no fault benefits, uninsured and/or underinsured motorist coverage, liability coverage, and malpractice coverage.

If I retain an attorney(s) to represent me in this matter, I will direct each attorney to issue a letter of protection (LOP) to NTXC&RC regarding my charges. Upon issuance, I agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of NTXC&RC. I further direct and NTXC&RC requests, that each attorney provide immediate notice to NTXC&RC regarding any funds received by said attorney(s), relating to my accident, and promptly pay NTXC&RC out of said funds and to provide a full accounting to NTXC&RC upon request.

I hereby authorize and direct NTXC&RC to file claims with my health insurance carrier. I understand that in the event my charges submitted in their full amount to any other form of insurance or source of payment (Ex. Personal Injury Protection, Liability, Med Pay, Attorney(s), etc.), I hereby authorize and direct NTXC&RC to collect any write-offs or discounts issues by my health insurance out of the proceeds from any other insurance or source of payment.

I hereby direct all payers to release to NTXC&RC any pertinent information regarding any coverage I may have included, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize NTXC&RC to release any information regarding my treatment or that may be pertinent to my case(s) to all payers as defined above to facilitate collection under the agreement. I hereby direct NTXC&RC to file a copy of this agreement together with any applicable charges, with any and/or all payers regardless of whether a claim has been established with said payers. I hereby authorize NTXC&RC to endorse and/or sign my name on any and all checks listing me as the payee, which are presented to NTXC&RC for payment on an account relating to me, my spouse and/or any of my dependents. I further authorize NTXC&RC to apply any credit balances or charges incurred by me or any other outstanding charges still owed by me, my spouse, and/or any of my dependents, regardless of whether those other charges are related to my condition.

I understand that I remain personally responsible and liable for the total amount(s) due to NTXC&RC for their services rendered to me. This agreement does not constitute any consideration for NTXC&RC, as its option, may demand payment immediately upon rendering services to me. If NTXC&RC must take action to collect an outstanding balance on my account, I will be responsible for the payment(s) and will reimburse NTXC&RC for all costs of such collection efforts including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoke without mutual written consent of NTXC&RC and myself. I hereby revoke any previously signed authorizations, whether executed at NTXC&RC, to the extent that the terms of those authorizations conflict with the terms of this agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the right and interests of NTXC&RC, however, should any provision of this Agreement be found invalid, illegal, unenforceable, or for any reason cease to be binding upon any part hereto, all other portions and provision of this Agreement shall, nevertheless, remain in full force and effect.

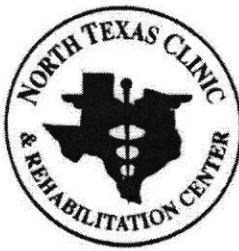
Executed On (Date): _____

Date Signed: _____

Patient Name (Printed): _____ Patient Signature: _____

Patient Representative/Legal Guardian (Printed): _____

Patient Representative/Legal Guardian Signature: _____



Worker's Comp Insurance Verification Form

Name: _____ Chart # _____ DOI: ____/____/____

Chief Complaint: _____ SS # _____ Claim # _____

Insurance Company Name: _____ Address: _____

Phone Number: _____

Fax: Number: _____ Is this address for submitting Claims ☐ Yes ☐ No
(If **NO**, what is address for claims)

Employer Name: _____ Phone Number: _____

Adjuster: _____ Ext: _____ T: _____ F: _____

1. Is this a traditional worker's comp insurance plan? ☐ Y ☐ N (If **YES**, skip to question 3.)

2. If **NO**, what type of plan is it? _____

3. Does this employer subscribe to a worker's comp Network? ☐ Y ☐ N _____

If 3 is No, skip to question 4.

A. What is the name of the network? _____

B. Is Dr. Skinner in network? ☐ Y ☐ N

4. What is the compensable injury/body part(s)? _____

5. Are there specific ICD 10 Codes on file? ☐ Y ☐ N (If **YES**, list codes) _____

Is a pre-certification required? ☐ Y ☐ N

Pre-Cert Company: _____ T: _____ F: _____

Comments: _____

Verified By: _____ Ref #: _____ Spoke to: _____ Date and Time: _____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date _____ Patient Name: _____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all

Somewhat difficult

Very Difficult

Extremely Difficult

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all

Somewhat difficult

Very Difficult

Extremely Difficult