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Injury Center of Houston

® An Affiliate of ICH Healthcare, P.A.

Case History & Patient Information

Name:_____ Driver Lic #: _____

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

Phone: Home (_____) _____ Cell (_____) _____ Work (_____) _____

S/S #:_____ Age: _____ Birth date:_____/_____/_____ Sex: M / F Status: □ M □ S □W □ D

Your Email:_____

Occupation:_____ Employer:_____ Type of Business:_____

Employer's Address:_____ Phone:_____ City:_____ State:_____ Zip :_____

Years Employed:_____ Phone:_____ Fax:_____ Supervisor:_____

What is your major compliant?: _____

_____

How were you referred to our office?_____

How long have you had this condition?:_____ Is this condition getting worse?: □ Yes □ No□ Constant □ Comes and goes

Have you had this or similar conditions in the past?: □ Yes □ No If Yes, when and describe:_____

_____

What activities aggravate your condition?:_____

List surgical operations:_____

_____

Are you taking any medications? □ Yes □ No What kind?: _____

Any non-prescription drugs? □ Yes □ No What kind?: _____

OTHER DOCTORS SEEN FOR THIS CONDITION □ MD □ DC □ DO □ DDS

Doctor's(Clinic) Name:_____Ph#_____ Diagnosis: _____

Did you go to the hospital? ( )Yes ( ) _No If yes, where: _____

INSURANCE INFORMATION:

Please check any and all insurance coverage that may be applicable in this case:

□ Major Medical □ Worker's Compensation □ Medicaid □ Medicare □ Auto Accident: □ Other:_____

Name if Insurance Company:_____ Claim #:_____ Group #:_____

Address:_____ Telephone (_____) _____ Agent: _____

Secondary Insurance Company(if any):_____ Claim #:_____ Group #:_____

Address:_____ Telephone (_____) _____ Agent: _____

Are your injuries related to an accident? □ Yes □ No **Is the accident work related?** □ Yes □ No **Were you involved in an Auto accident?** □ Yes □ No

Date of Accident:_____ Are you off work? □ Yes □ No If so, how long? : _____

In your own words, please describe accident:_____

_____

_____

Do you have an attorney?: □ Yes □ No Name :_____ Phone (_____) _____

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

If your injuries are from an Auto accident please complete below:

Your Auto Ins. Co.:_____Policy#:_____Claim#_____

Agent's Name: _____Phone#_____

Third Party's Auto Ins:_____

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

Policy Holder's Name:_____ Phone# :_____ Claim #:_____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

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Patient Symptoms

IMPORTANT: Please check (X) all the present symptoms.

HEAD:
- □ Headache
  - □sinus (allergy)
  - □ Entire head
  - □ Back of head
  - □ Forehead
  - □ Temples
  - □ Migraine
- □ Head feels heavy
- □ Loss of memory
- □ Light-headedness
- □ Fainting
- □ Light bothers eyes
- □ Blurred vision
- □ Loss of vision
- □ Loss of taste
- □ Loss of balance
- □ Dizziness
- □ Loss of hearing
- □ Ringing in ears
- □ Buzzing in ears

NECK:
- □ Pain in neck
- □ Neck pain with movement
  - □ Forward
  - □ Backward
  - □ Turn to left
  - □ Turn to right
  - □ Bend to left
  - □ Bend to right
- □ Pinched nerve in neck
- □ Neck feels out of place
- □Muscle spasms in neck
- □ Grinding sounds in neck
- □ Popping sounds in neck
- □ Arthritis in neck

SHOULDERS:
- □ Pain in shoulder joint (R-L)
- □ Pain across shoulders
- □ Bursitis (R-L)
- □ Arthritis (R-L)
- □ Can't raise arm
  - □ Above shoulder level
  - □ Over head
- □ Tension in shoulders
- □ Pinched nerve in shoulder (R-L)
- □ Muscle spasms in shoulders

ARMS & HANDS:
- □ Pain in upper arm
- □ Pain in elbow
- □ Movement aggravated
- □ Tennis elbow
- □ Pain in forearm
- □ Pain in hands
- □ Pain in fingers
- □ Sensation of pins & needles in arms
- □ Sensation of pins and needles in fingers
- □ Numbness in arms (R-L)
- □ Numbness in fingers (R-L)
- □ Fingers go to sleep
- □ Hands cold
- □ Swollen Joints in fingers
- □ Sore joints in fingers
- □ Arthritis in fingers
- □ Loss of grip strength

MID-BACK:
- □ Mid-back pain
- □ Location:_____
- □ Pain between shoulder blades
- □ Sharp stabbing
- □ Dull ache
- □ Pain from front to back
- □ Muscle spasms
- □ Pain in kidney area

CHEST:
- □ Chest pain
- □ Shortness of breath
- □ Pain around ribs
- □ Breast pain
- □ Dimpled or orange peel breast
- □ Irregular heartbeat

ABDOMEN:
- □ Nervous stomach
- □ Foods can't eat:_____
- □ Nausea
- □ Gas
- □ Constipation
- □ Diarrhea
- □ Hemorrhoids

LOW BACK:
- □ Low back pain
  - □ Upper lumbar
  - □ Lower lumbar
  - □ Sacroiliac
- □ Low back pain is worse when:
  - □ Working
  - □ Lifting
  - □ Stooping
  - □ Standing
  - □ Sitting
  - □ Bending
  - □ Coughing
  - □ Lying down (sleeping)
  - □ Walking
- □ Pain relieves when:_____
- □ Slipped disc
- □ Low back feels out of place
- □ Muscle spasms
- □ Arthritis

HIPS, LEGS & FEET:
- □ Pain in buttocks (R-L)
- □ Pain in hip joint (R-L)
- □ Pain down leg (R-L)
- □ Pain down both legs
- □ Knee pain
  - □ Inside
  - □ Outside
- □ Leg cramps
- □ Cramps in feet (R-L)
- □ Pins & needles in legs (R-L)
- □ Numbness of leg (R-L)
- □ Numbness of feet (R-L)
- □ Numbness in toes
- □ Feet feel cold
- □ Swollen ankles (R-L)
- □ Swollen feet (R-L)

WOMEN ONLY:
- □ Menstrual pain _____(where)
- □ Cramping
- □ Irregularity
- □ Cycle _____ days
- □ Birth Control _____ (type)
- □ Hysterectomy
- □ Genital Cancer _____
- □ Discharge
- □ Menopause
- □ Tumors
- □ Abortions
- □ Are you or do you think you are pregnant?

MEN ONLY:
- □ Urinary frequency
- □ Difficulty in starting
- □ Night urination
- □ Prostate pain/swelling

GENERAL:
- □ Nervousness
- □ Irritable
- □ Depressed
- □ Fatigued
- □ Generally feel run-down
- □ Normal Sleep _____
- □ Loss of sleep _____ hrs./night
- □ Loss of weight _____ lbs.
- □ Gain weight _____ lbs.
- □ Coffee _____ cups/day
- □ Tea _____ cups/day
- □ Cigarettes _____ packs/day
- □ Diabetes
- □ Hypoglycemia

Last Date of Immunization:
- □ Flu: Date: _____
- □ Tetanus: Date: _____
- □ Pneumovax: Date: _____
- □ Other: _____
  Date:_____

REMARKS:

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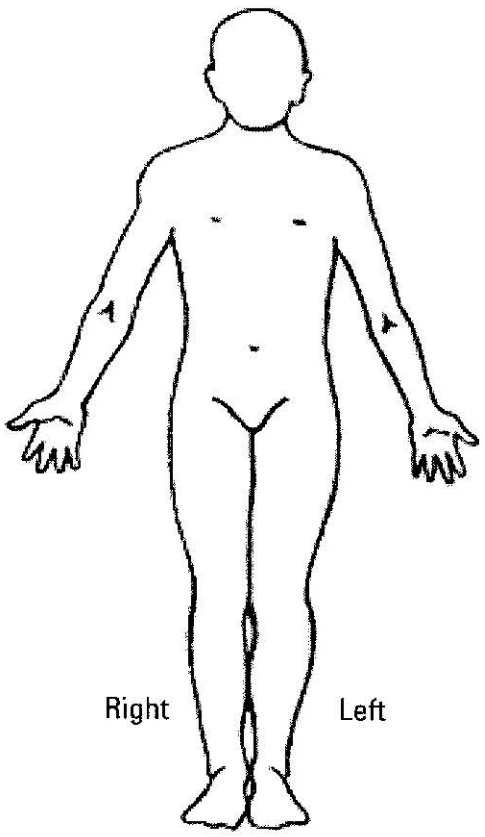
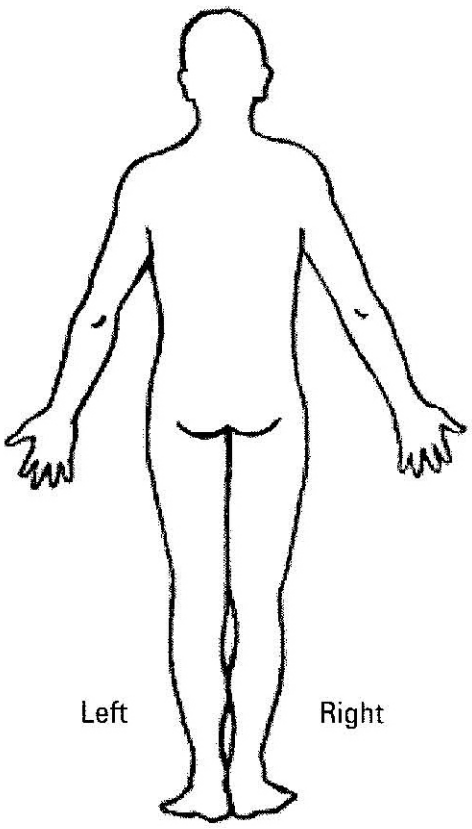
Patient Symptoms

Use the pictures below to indicate your problem areas. Use the appropriate symbol to indicate numbness, pins and needles, burning, stiffness, aching or stabbing pain.

Numbness: □ Pins & Needles: -- Aching Pain: +
Stabbing Pain: ^ Burning: # Stiffness: **





Please rate your discomfort on a scale of 1-10
(1=mild pain, 10 = the worst pain you've ever felt)

Location Pain Rating

1._____

2._____

3._____

4._____

Injury Center of Houston

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TO: PATIENTS OF INJURY CENTER OF HOUSTON

The Injury Center of Houston specializes in the treatment of the spine and musculoskeletal system. We perform various treatments consisting of passive modalities, therapeutic interventions and spinal manipulation. The goal of our services is to reduce and/or eliminate your pain, however, as with any chiropractic and/or physical medicine services there are risks associated with the services we provide.

As your healthcare provider, we feel that it is crucial that you understand these risks. By informing you of these risks we are striving to more actively involve you in our case as well as further assist you in making well-informed decisions regarding your treatment options.

PASSIVE MODALITIES

Passive modalities consist of the following treatments: hot packs, cold packs, ultrasound, electrical stimulation, massage, traction, paraffin, whirlpool and iontophoresis.

The primary risk associated with the passive modalities is skin irritation due to exposure to heat, cold or agents used in the application of modalities, i.e. lotions, pads, paraffin and/or iontophoresis (lidocaine/hydrocortisone). If you have experienced skin sensitivity to heat, cold temperatures and/or lotions or similar products in the past or are aware of any skin allergies, please inform our staff prior to treatment so proper precautions can be made prior to initiating treatment.

THERAPEUTIC INTERVENTIONS

Therapeutic interventions consist of the following types of treatments: stretching, flexibility exercises, strengthening exercises, joint mobilizations and myofascial release.

Therapeutic interventions are generally quite safe though there are risks associated with each of these procedures. The primary risk is potential aggravation of your current condition and/or underlying condition. As with any physical activity and/or exercise there is also the risk of injury. Though this risk is minimal as you are under the direct supervision of experienced clinical staff, it may still exist.

Some responses to therapeutic interventions are muscle soreness, muscle fatigue, increased discomfort, overall tiredness and/or joint stiffness and/or pain. It is important that you inform your treating staff member of any of these responses following your treatment and more importantly it is crucial that you continue to attend your appointments as scheduled so your condition can be documented and your symptoms effectively managed.

SPINAL MANIPULATION

Spinal manipulation consists of adjustments that seek to restore normal function to the spine and other joints. Typically, this involves applying a specific, highly controlled treatment directly to a joint or muscle. This treatment often reduces or eliminates both local and referred pain, allows muscle spasms to relax, and may even release the irritation from the nervous system, which may result in other health benefits.

As with any healthcare service there are potential reactions and risks, however as with any healthcare intervention, it is hoped that the expected benefits of spinal manipulation exceed the expected risks. These are unavoidable risks of spinal manipulation which, though rare, can occur.

DISK HERNIATION

The occurrence of disk herniation during spinal manipulation is highly unlikely. In fact, average disks withstand an average of 23 degrees of rotation and degenerated disks an average of 14 degrees of rotation before failure occurs. Furthermore, given the fact that during manipulation posterior facet joints limit rotation to a maximum of 2-3 degrees, this joint would have to fracture to allow any further rotation to occur.

CAUDA EQUINA SYNDROME

It is estimated that the rate of occurrence of the cauda equine syndrome as a complication of lumbar spinal manipulation is about one case per 100 million manipulations. It is probably higher in patients with a herniated nucleus pulposus, and lower in patients without this anatomic abnormality.

VERTEBROBASILAR ARTERY COMPROMISE

Serious complication of cervical spine manipulation are also rare (none having been reported in any of the clinical trials), but appear to be more common and severe than complication of lumbar manipulation. The most serious complication of the cervical spine manipulation is related to compromise of the vertebrobasilar artery, leading to stroke or death. The risk is higher for manipulation involving rotation plus extension of the cervical spine than for other types of manipulation, and those persons who have suffered manipulation-related vertebrobasilar artery compromise due to atherosclerotic disease. The best estimate of the incidence of vertebrobasilar artery compromise related to cervical spine manipulation is that it occurs one in 1 million manipulations (Hurwitz, 1996; McGregor, 1995).

PATIENT UNDERSTANDING AND ACCEPTANCE OF RISKS ASSOCIATED WITH TREATMENT

As your doctor it is our responsibility to inform you of the potential risks and benefits of your treatment, but we also want to assure you that we strive to minimize these risks by providing thorough clinical examinations and by performing diagnostics as clinically indicated. Furthermore, we continually review medical literature pertaining to current trends within our profession as well as throughout the entire medical community to ensure the safest and most effective care.

I have reviewed the information provided regarding the benefits and risks of treatment provided at the Injury Center of Houston. I have been given the opportunity to discuss my questions and/or concerns and by signing below I acknowledge that I understand and accept the risks associated with my treatment.

Patient Signature _____ Date _____

Guardian's Signature _____ Date _____

HEALTH CARE PROVIDER LIEN/CONTRACTURAL LIEN / ASSIGNMENT OF BENEFIT
INTENDED 3RD PARTY VESTED INTEREST – TEXAS CASE LAW

I,_____ (hereinafter referred to as "patient") and/or responsible party, in addition to continuing personal responsibility in consideration of treatment rendered or to be rendered by Injury Center of Houston agrees as follows:

1. ***Release of Information*:** Injury Center of Houston shall have the authority to release information concerning the Patient's condition and treatment to any of his/her insurance companies, attorneys, or insurance adjusters, for purpose of processing any relevant claims for benefits and payment of services rendered to the patient. Information, if any, only be released upon proper written request to do by said Insurance Company, Attorney, or Adjuster. Any other release of information regarding the patient's treatment shall be accomplished by execution of separate release agreement.

2. ***Irrevocable Assignment of Rights*:** Injury Center of Houston is hereby assigned the exclusive, irrevocable interest in any cause of action that exist in the patient's favor against any insured, agent of any insured or insurance company benefits to the extent of Injury Center of Houston charges for services rendered to the patient, if such benefits are owed within the terms of the policy, including the exclusive irrevocable rights to receive payment for such services, make demand in his/her name for payment and prosecute, or retain an attorney to prosecute and receive penalties, interest, court cost or legally compensable amounts owed by an insured, agent for the insured or insurance company, in accordance with Article 3.62 of the Texas Insurance Code or the applicable insurance or state statue. The patient and or responsible party, further agrees to cooperate and provide information as needed and appears as needed, whenever to assist the prosecution of such claims for benefits upon request.

3a. ***Authorization and Directives:*** the patient and/or responsible person hereby authorizes and directs any or all insurance companies, known or unknown, providing monies or benefits of any kind to said patient to pay directly to Injury Center of Houston such sums as may be due and owing him/her for medical services rendered to the patient, within thirty (30) days following the insurance company's receipt of bill for service, along with a copy of this agreement, to the extent said bills are payable under the terms of the relevant policy. This demand specially conforms to Article 3.62-1 of the Texas Insurance Code, providing for Attorney fees, twelve percent (12%) penalty, court cost, and interest from judgment on violation.

3b. ***Lien Interest:*** Any and all relevant insurance companies whether known or unknown, at the time of execution of this agreement, shall be authorized to withhold said sums from any settlement, judgment or verdict paid as may be necessary to adequately protect Injury Center of Houston from loss. In addition to the agreements contained herein, I hereby authorize, give or grant lien interest in favor of Injury Center of Houston against any and all proceeds for said settlement, judgment or verdict. I also agree, authorize, allow Injury Center of Houston to file a HEALTH CARE PROVIDER LIEN, AND/OR COMMON LAW CONTRACTURAL LIEN, with the proper county clerk office for any unpaid balances that results from charges owed to Injury Center of Houston for professional services provided to me as a result of this injury or illness.

3c. ***Intended 3rd Party Beneficiary Vested Interest***: Let it be known, under the term of this agreement, the patient has named and agreed to name Injury Center of Houston as the intended third party beneficiary with vested interest with shall have full effect and enforcement under Texas Case Law, on any and all interest owed to the patient for medical services rendered. In the event any or all insurance companies, whether known or unknown, fail or refuse to make such payment to Injury Center of Houston as hereinabove directed, the patient is hereby assigned and transferred any and all cause of action that may exist in the patient's favor, authorizing Injury Center of Houston to prosecute such action either in the patient's name and/or clinic's name as joinder, or as otherwise legally required, and further grant authorization to compromise, settle or otherwise resolve said claim at Injury Center of Houston discretion. It is acknowledgement that whatever sums are left outstanding from payment of insurance proceeds is the personal obligation of the patient or responsible party, but the power to collect such sums for the patient or responsible person is effective only after Injury Center of Houston has made all reasonable efforts to collect the sum due from relevant insurance company (ies). Moreover, patient and/or responsible party, agree that if there is an unpaid balance owed to Injury Center of Houston and insurance benefits are received directly by patient or responsible party, he/she will immediately pay the account in full. Upon failure to pay insurance benefits to Injury Center of Houston, patient agrees to pay attorney fee and court cost incurred should legal action is required against patient by Injury Center of Houston to collect any and all balance owed.

4. ***Limited Power of Attorney for Insurance Benefits***: The patient and/or responsible person hereby grants to Injury Center of Houston the authority to endorse the name of the patient upon any check, draft, or other negotiable instrument representing payment from any insurance company for treatment and health care rendered by Injury Center of Houston. Patient agrees that nay insurance payment representing an amount of excess of the charges for treatment rendered will be credited to patient's account or forwarded to the patient's address upon written request to Injury Center of Houston.

5. ***Review of Assignment of Benefits Agreement Consideration***: In making this irrevocable assignment of interest/provider health care lien authorization, I acknowledge that I have read and understand the foregoing, that I received good and valuable consideration for making this agreement, and that I am under no duress, but make irrevocable assignment of interest/provider health care lien authorization voluntarily by my own free will.

In consideration to patient's agreement, Injury Center of Houston is willing to wait for payment directly from insurance company, if the insurance company agrees to pay Injury Center of Houston. In any event, patient and/or responsible person understands that he or she is personally responsible for any and all bills at this office.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL

_____	_____	_____
Patient Name – (Print)	Patient Signature	Date Signed
_____	_____	_____
Witness / Notary Name (Print)	Witness/Notary Signature	Date Signed

Injury Center of Houston

An Affiliate of ICH Healthcare, P.A
11100 Southwest Freeway
Houston, Texas 77031

Medical Records Release Authorization

Patient Name_____ D.O.B._____ SS# _____

Address: _____ Phone #: _____

I hereby authorize_____
(***Facility Name***)
To release information from the medical records of _____
(***Patient's Name***)
For Treatment dates: _____
(***Specific dates***)
To: ***The Injury Center of Houston, 11100 Southwest Freeway, Houston, TX 77031***
Fax #: ***713-771-1876*** Phone #: ***713-771-2225***

I hereby authorize and request that you release and deliver all my medical records including,

□ Abstract/ pertinent Information
□ Nurses Notes
□ History & Physical
□ M.D. Orders
□ M.D. Progress Notes
□ Imaging/ Radiology
□ Laboratory results
□ Operative/ Procedure Report
□ Cardiac Studies
□ Face Sheet

□ Entire record **Excluding** - HIV Testing & Chemical Dependency
□ Entire record **Including** - HIV Testing & Chemical Dependency
□ Entire record **Including** - HIV Testing only.
□ Entire record **Including** - Chemical Dependency only.
□ Itemized Bill/ ledger
□ Other

I, the undersigned, have read the above and authorize _____to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that the action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may be no longer be protected. I hereby release and hold harmless the above named facility and its parent company from all liability and damages resulting from the lawful release of my Protected Health Information.

_____ _____ _____
Date Patient/ Guardian Signature Relationship to Patient

Injury Center of Houston

An Affiliate of ICH Healthcare, P.A.
11100 Southwest Freeway
Houston, Texas 77031
Office 713-771-2225 Fax 713-771-1876

Acknowledgement of Review and Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent.

By signing this form, you consent to the use and disclosure of protected health information about you for treatment, payment and other healthcare operations. Injury Center of Houston provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
I authorize that Injury Center of Houston may contact me in the following manner (check all that apply):
Home Telephone:

- ❒ OK to leave detailed message on answering machine or voicemail
- ❒ OK to leave message on machine or voicemail with call-back number only
- ❒ OK to leave message with family member or person answering call
- ❒ Do not leave message

Work Telephone:

- ❒ OK to leave detailed message on answering machine or voicemail
- ❒ OK to leave message on machine or voicemail with call-back number only ıı OK to leave message with family member or person answering call
- ❑ Do not leave message

Cellular Telephone:

- ❒ OK to leave detailed message on voicemail
- ❒ OK to leave message with call-back number only
- ❒ Do not leave message

_____
Patient Signature or Patient Representative Date

_____
Printed Name of Patient or Patient Representative

_____
Description / Relation of Patient Representative Authority

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Houston, Texas 77031
Office 713-771-2225 Fax 713-771-1876

URINE DRUG SCREENING

As part of your treatment plan, you may be prescribed a narcotic to control your pain. You may also be prescribed other controlled substances such as muscle relaxers, sleeping aids, or anxiolytics. As discussed in your medication agreement, these types of medications have potential serious side effects, and also have potential for misuse, abuse, and diversion.

In order to protect your right, as a patient with chronic pain, to obtain these medications for legitimate medical use, our practice uses a Urine Drug Screening (UDS) process. This Urinalysis will screen for the medication you are taking, and will also screen for illegal substances and non-prescribed controlled substances. All results will remain a part of your medical record with our office and will be used to guide your treatment.

All patients who are prescribed these medications will be asked to undergo random Urine Drug Screens as part of the process, without exception, and without regard to age, race, sex, past medical history, or current diagnosis. The frequency of this screening will vary depending on your personalized treatment plan and risk factors.

The bill for this screening will be submitted to your insurance company and will follow all customary billing policies. Injury Center of Houston (ICH) may have an ownership interest in the laboratory utilized. If you do not wish to use a lab assigned by ICH, and you have a designated lab you desire to perform the UDS, our staff will be happy to accommodate your request. We do not want this process to appear punitive or negative, and appreciate your participation in protecting your right as a chronic pain patient, and our rights as a medical practice.

Thank you,

Patient's Name:_____Date:_____

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Medication Policy Physician - Patient Contract

Please be advised our policy has changed and will be enforced. Please initial by each policy.

- Patients are required to see their physician in order to receive a prescription for controlled medications (narcotics, sedatives, anti-anxiety medications, Hydrocodone and Tramadol,) NO REFILLS WILL BE AUTHORIZED BY FAX OR PHONE. Prescriptions will not be available for pick-up without seeing the physician. _____

- The patient is responsible for scheduling appointments in a timely manner to avoid running out of medication. Please note that the patient risks possible symptoms of withdrawal if he/ she fail to schedule the follow up appointment. Please call at least one week in advance to schedule your follow-up appointment. _____

- Long term use of controlled medications can cause physiological and/or psychological dependence. Therefore, compliance with medication usage is monitored and if any abuse is determined, the patient will be expeditiously weaned off the medication and referred to a substance abuse program. _____

- Patients receiving controlled medications (narcotics, muscle relaxants, sedatives or anti-anxiety medications) are responsible for the care of these medications. Any lost, stolen or mishandled medications will be refilled on a case by case basis. The patient must provide our office with a detailed-police report if any medication is stolen. If a medication is lost, a notarized letter from the patient stating the details of the loss must be provided to the office. Once the police report or notarized letter is returned in to our office, only then will the doctor review it and determine if the refill is appropriate. _____

- Patients prescribed controlled medications may be asked to perform a random urine drug screen test. Refusal to cooperate with this testing will result in a non-refill of medications. *Any positive results for illicit drugs or controlled medications not prescribed by this office may result in discontinuation of controlled medications by this office. Patient is responsible for declaring all controlled medications that they are taking to their physician.* _____

- If a patient is receiving controlled medications from our office, it is our policy that the patient may not receive controlled medications from another physician unless prior arrangements are made, and documented with our physician. Deviation of this policy may result in the termination of treatment by this office. This is for the patient's safety and well-being. _____

- Take medications only as prescribed. If the prescribed medication is not effective in controlling your symptoms, call your physician first before taking more than prescribed. Never take more medications than prescribed unless your physician instructs you to do so, doing so is a violation of this contract. No early refills will be given if the medication dose is altered without prior authorization from our physician. _____

- **All controlled medication will be filled for a 28-day supply.** _____

- Provisions will be made in the event that your refill date falls on a holiday. _____

By signing, I am stating I have read and fully understand this physician-patient contract:

X _____ X_____
Print Name Patient's Signature

Date:_____

Policyholder:
Claim Unit Number:
Policy Number:
Injured Party:
Claim Handler:

ASSIGNMENT OF BENEFITS

This form will allow us to pay any covered medical expenses directly to your physician or other health care provider. Many people consider this more convenient and may assure the provider is paid more promptly. Otherwise, our payments will be sent to you and you would be responsible for making payments to the providers.

To authorize us to make payments directly to your medical providers, please sign and return this form along with your Application for Benefits and Medical Authorization.

PLEASE SIGN & RETURN IF YOU WOULD PREFER YOUR MEDICAL PROVIDERS TO BE PAID DIRECTLY:

SIGNATURE:_____ DATE:_____

NOTE IF YOU MADE AN ASSIGNMENT OF BENEFITS TO THE MEDICAL PROVIDER, WE ARE OBLIGATED BY THE POLICY PROVISIONS TO MAKE PAYMENTS TO THE PROVIDER.