UNITED THERAPY ASSOCIATES, P.A.

6714-I RITCHIE HIGHWAY • GLEN BURNIE, MARYLAND 21061

410-787-2229 • FAX 410-787-0141

DR. LAWRENCE S. SAEZ, DC, MUAC

MONICA L. SAEZ, OTR/L

WORKERS COMPENSATION QUESTIONNAIRE

Last Name_____First _____Middle_____ [ ] Male [ ] Female

Home Phone ___-___-____ Cell ___-___-____ Work ___-___-____

Email address_____Date of Birth __-__-__ Social Security Number ___-__-____

Address_____ City_____ State_____ Zip_____

Occupation_____ (Indicate if child, student, homemaker, unemployed, retired)

Spouse's Name_____ Spouse's Soc. Sec. # ___-__-____

Present Employer's Name_____Phone_____

Address_____

Employer at time of injury: _____

Supervisor's name:_____ Telephone _____

Claim Number_____

Did you report this injury to your employer?_____ If so, date _____

Please explain how this injury occurred_____

_____

_____

_____

Do you have an attorney? ☐ Yes ☐ No If so, name and address_____

_____

Date present injury occurred __/__/__ Time_____ ☐ AM ☐ PM

Where did you feel pain immediately after the accident?_____

Did you return to work? ☐ Yes ☐ No If so, date returned to work_____

Did you go to the hospital? ☐ Yes ☐ No Did you consult any other doctor? ☐ Yes ☐ No

If so, give doctor's name _____ ☐ D.C., ☐ M.D., ☐ D.O., ☐ D.D.S.

What did the doctor say was wrong with you?_____

Circle what treatments you received. **X-RAYS** **M.R.I.** **MEDICATION**

PHYSICAL THERAPY **OTHER** _____

Did your doctor give you a prescription for physical therapy? YES NO

Have you ever injured this area before? ☐ Yes ☐ No If so, when _____

If injured before, did you lose time from work? ☐ Yes ☐ No

OVER

Do any other diseases or accidents affect your employment? ☐ Yes ☐ No If so, explain _____

_____

In your work do you have to favor any part of your body? ☐ Yes ☐ No If so, explain _____

_____

How many days have you missed from work due to other work related injuries?_____

Have you ever had a Workers Compensation claim before? ☐ Yes ☐ No Date_____

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No If so, explain _____

_____

Since this injury are your symptoms ☐ improving? ☐ getting worse? ☐ the same?

HEALTH QUESTIONNAIRE:

Please indicate for each of the questons below your experience by use of the following codes:

1- never had 2- previously had 3-presently have

MUSCULO-SKELETAL SYSTEM

Low back problems
_____ Pain between shoulders
_____ Neck problems
_____ Arm problems
_____ Leg problems
_____ Swollen joints
_____ Painful joints
_____ Stiff joints
_____ Sore muscles
_____ Weak muscles
_____ Walking problems
_____ Ruptures
_____ Broken bones

GENITO-URINARY SYSTEM

_____ Bladder trouble
_____ Excessive urination
_____ Scanty urination
_____ Painful urination
_____ Discolored urine

FEMALE

_____ Vaginal discharge
_____ Vaginal bleeding
_____ Vaginal pain
_____ Breast pain
_____ Lumps on breast
Are you pregnant? **YES NO**

GASTRO-INTESTINAL SYSTEM

_____ Poor appetite
_____ Excessive hunger
_____ Difficult chewing
_____ Difficult swallowing
_____ Excessive thirst
_____ Nausea
_____ Vomiting food
_____ Vomiting blood
_____ Abdominal pain
_____ Diarrhea
_____ Constipation
_____ Black stool
_____ Bloody stool
_____ Hemorrhoids
_____ Liver trouble
_____ Gall bladder problems
_____ Weight trouble

NERVOUS SYSTEM

_____ Numbness
_____ Loss of feeling
_____ Paralysis
_____ Dizziness
_____ Fainting
_____ Headaches
_____ Muscle jerking
_____ Convulsions
_____ Forgetfulness
_____ Confusion
_____ Depression

CARDIO-VASCULAR-RESPIRATORY SYSTEM

_____ Chest pain
_____ Pain over heart
_____ Difficult breathing
_____ Persistent cough
_____ Coughing phlegm
_____ Coughing blood
_____ Rapid heartbeat
_____ Blood pressure problems
_____ Heart problems
_____ Lung problems
_____ Varicose veins

EYE, EAR, NOSE, AND THROAT

_____ Eye strain
_____ Eye inflammation
_____ Vision problems
_____ Ear pain
_____ Ear noises
_____ Hearing loss
_____ Ear discharge
_____ Nose pain
_____ Nose bleeding
_____ Nose discharge
_____ Difficult breathing
_____ Sore gums
_____ Dental problems
_____ Sore mouth
_____ Sore throat
_____ Hoarseness
_____ Difficult speech

Patient's Signature_____ Date_____

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ACTIVITIES OF DAILY LIVING

Rate the level of difficulty that you are having with the following activities
From 1-5 (1=minimum difficulty, 5=unable to perform)
{Leave blank if no difficulty}

Living:
_____Bending over
_____Sitting for greater than _____
_____Standing for greater than _____
_____Walking for greater than _____
_____Reaching overhead
_____Driving a car
_____Looking over your shoulder
_____Sleeping for greater than _____
How long can you sleep undisturbed?
_____
_____Lying on back
_____Lying on side {R or L}
_____Lying on stomach

Dressing:
_____Putting on a blouse/shirt
_____Fastening buttons/zippers in back
_____Putting on a coat
_____Putting on a pullover shirt/sweater
_____Putting on shoes/socks
_____Putting on pants/slacks

Work:
_____Lifting
_____Carrying objects
_____Using a computer
_____Using the phone
_____Other: _____

Describe physical demands of daily work or activities:
_____
_____
_____
_____

_____Ascending stairs
_____Descending stairs
_____Buckling seatbelt
_____Sweeping/Mopping
_____Child care activities
_____Cooking
_____Doing yard work
_____Shoveling
_____Getting out of a chair
_____Getting out of bed
_____Other: _____

Hygiene:
_____Washing your hair
_____Washing your feet
_____Washing your back
_____Putting on deodorant
_____Shaving face/legs
_____Other: _____

Leisure:
_____Reading
_____Watching TV
_____Other: _____

Have you experienced any of the following since the onset of your symptoms?
_____Headaches
_____Irritability
_____Loss of attention
_____Fatigue
_____Bowel or bladder dysfunction
_____Dizziness or nausea

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NON-PREGNANCY VERIFICATION

Name _____ Date of Birth _____

I, _____ hereby notify all concerned, that I neither suspect nor know positively at this time that I may be or am pregnant. I release United Therapy Associates from any and all damages arising from any and all procedures, of a diagnostic or treatment nature with reference to the possibility of pregnancy.

Signature of Patient _____

Date _____

Witness _____

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ACKNOWLEDGEMENT OF HEALTH INFORMATON PRIVACY PRACTICES

I, _____, acknowledge that by signing this form, I have received notice of the Health Information Privacy Practices from United Therapy Associates, P.A.

Patient's Signature:_____Date_____

Witness _____Date_____

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AUTHORIZATION TO PAY PROVIDER

I hereby authorize the _____Insurance Company to pay by check made out and mailed directly To: UNITED THERAPYASSOCIATES, P.A. 6714-1 Ritchie Highway Suite I, Glen Burnie, MD 21061, the medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment towards the total charges for Professional Services rendered. This payment will not exceed my indebtedness to the above-mentioned assignee, and I agree to pay, in a current manner, any balance of said Professional Service over and above the insurance payment.

If my current policy prohibits direct payment of provider, then I hereby authorize you to make the check to me and mail it as follows: c/o United Therapy Associates, P.A. 6714 Ritchie Highway Suite I, Glen Burnie MD 21061. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertaining to my case to any insurance company, adjuster or attorney.

CONSENT TO TREAT A MINOR

I hereby authorize United Therapy Associates, P.A. and whomever it may designate, as its therapists/assistants to administer treatment as it deems necessary to
Child's Name: _____Birth Date:_____

_____ _____

Signature of Parent or Guardian Relationship to Child

MEDICAL RELEASE AUTHORIZATION

I, _____, Hereby authorize any hospital, physician, health care provider or facility to furnish United Therapy Associates, P.A. with any and all information pertaining to any illness, disease, injury, history or treatment and a copy of all records.

Date: _____

Patient Name: _____

Signature of Patient: _____

Witness: _____

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OFFICE FINANCIAL POLICY

Our office policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us in order to reduce your out-of-pocket expenses.

If you have health insurance, all deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $150 or care may be terminated. Our payment plans make care an affordable part of your budget.

You are considered a self-pay patient until you bring completed insurance forms, insurance card, and we verify and accept your insurance coverage.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

Patient's Printed Name: _____

Signature: _____ Date: _____

Front Desk Staff: _____ Date: _____

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FACILITY/PROVIDER'S LIEN

To: Attorney/Insurance Carrier

_____

_____

_____

_____

Please date, sign and return copy to facility/providers office via fax to 410.761.2096

Facility: United Therapy Associates, P.A.
6714 Ritchie Highway, Suite I
Glen Burnie, MD 21061

I do hereby authorize the above facility/provider to furnish you, my attorney/insurance carrier, with a full report of my case history, examination, diagnosis, treatment and prognosis of myself in regard to my accident/illness which occurred/began on _____.

I hereby give a lien to said facility/provider on any settlement, claim, judgment, or verdict as a result of said accident/illness, and direct you, my attorney/insurance carrier, to pay directly to facility/provider such sums as may be due and owing from facility for services rendered to me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect said facility/provider adequately.

I fully understand that I am directly and fully responsible to said facility/provider all bills submitted by the facility/provider for services rendered to me, and that this agreement is made solely for said facility/provider additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

Date: _____ Patient Signature: _____(seal)

Patient Name (print): _____(seal)

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same and protect adequately said above names facility/provider.

Date: _____ Authorized Signature: _____ (seal)

Patient Name (print): _____(seal)

Title: _____

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ACKNOWLEDGEMENT OF HEALTH INSURANCE BILLING

I understand and agree that the above office will bill my private health insurance for services rendered once information is received that my personal injury protection benefit is exhausted or my workers compensation carrier denies payment.

I am responsible for any co-payments, co-insurance, and or deductibles at the time of service and will pay directly to the above provider/facility.

I understand that the above office will bill my automobile insurance policy under personal injury protection and does not bill automobile insurance carriers other than my own.

In the event that a duplicate payment is made to the above facility, reimbursement will be made to the insurance company directly.

I do hereby authorize the above facility/provider to bill my personal health insurance carrier and pay directly to the said provider for all services rendered.

Patient Signature _____ Date _____

Witness _____ Date _____

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MISSED APPOINTMENT POLICY

Please be advised of our missed appointment policy. This office requires **24 hours notice** for a missed appointment. If 24 hours notice is not received, a $25.00 fee will be charged that is not payable by your insurance company. In order to avoid this charge; please notify our office accordingly in the event an appointment must be rescheduled.

Date: _____

Patient Name: _____

Signature of Patient: _____

Witness: _____