Understanding Workers Compensation & Alpha Neurology's Services

We all understand that Workers Compensation laws are designed to ensure that employees who are injured or disabled on the job are provided with wage replacement and medical and rehabilitation benefits. However these services are limited to the **specific part of the body that was injured** on the job and that is not always clear.

When a Workers Compensation case is established, a **"body part injury"** is also established. As a result of this a physician is **allowed to treat that established body part only** and submit his charges to the Workers Compensation Board for payment for his services. In turn the Workers Compensation Board will authorize payment for that treatment as long as it is for the part of the body that was designated as injured on the job.

While the Providers at Alpha Neurology believe in treating the whole patient, we are severely limited as to what Workers Compensation will reimburse our practice for.

Hopefully this will help our patients understand our limits. The following pages need to be completed, in full, in order for us to begin your treatment.

We all dislike filling out forms; however the more information we have when you enter our office, the quicker you will be seen and the better we are prepared to serve you.

Alpha Neurology PC – Workers Compensation Information

Last Name | First Name | Middle Name | Date of Birth | Sex

Address | Social Security Number

City | State | Zip code | Cell Phone | Home Phone

Referring Physician or Provider Name | Address | Phone Number

Date of Injury / / | Time of injury _____ AM PM | Address, including State where injury occurred-

Retained Lawyer's Name, Address and telephone number:

Occupation | Describe your usual activities On the day of your injury

Describe your injury and how it occurred

Pharmacy Name, Address and Phone Number

Do you have a history of same or similar condition? __Yes __No If yes, state when and describe below:

Enter Employer Name when INJURY Occurred:
Address

Phone Number **Employer Contact Name**

ENTER WORKERS COMPENSATION INSURANCE INFORMATION

Insurance Name

Insurance Address | City | State | Zip code

Policy Number | Insurance Case Number | WCB Case Number

Claim Adjusters Name | Insurance Phone Number

ENTER YOUR COMMERCIAL INSURANCE IONFORMATION (ex: GHI, Cigna, Aetna, Medicare

Insurance Name

Insurance address | City | State | Zipcode

Insurance ID Number | Insurance Phone Number

Alpha Neurology PC

Name_____ Date_____

PAST Medical History: Have you been diagnosed with any of the following?

☐ Heart Disease	☐ Parkinson's disease	☐ Neuropathy	☐ Lupus	☐ Obesity
☐ Coronary Artery Disease	☐ Multiple Sclerosis	☐ Stroke	☐ Gout	☐ COPD/Emphysema
☐ Diabetes Mellitus	☐ Pacemaker	☐ Rheumatoid Arthritis	☐ Carpal Tunnel	☐ High Cholesterol

Other_____

_____

Previous Surgeries_____

_____

_____

Family History:	Father	Mother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Stroke	☐	☐	☐	☐	☐	☐
Seizure	☐	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐	☐
Parkinson's Disease	☐	☐	☐	☐	☐	☐
Migraine Headache	☐	☐	☐	☐	☐	☐
Neuropathy	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Respiratory Disease	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Psychiatric Disorder	☐	☐	☐	☐	☐	☐
Sudden, unexplained death	☐	☐	☐	☐	☐	☐

Social History:

Smoking: ☐ Yes, how many packs per day?_____ ☐ No, never ☐ Quit, when_____

Alcohol Use: ☐ Daily ☐ Socially

Recreational Drug use: ☐ Yes ☐ No

Employment: ☐ Employed ☐ Part Time ☐ Unemployed ☐ Retired

Marital Status: ☐ Single ☐ Married/Cohabitating ☐ Divorced/Separated ☐ Widowed

Have you, or a close family member or friend recently suffered any emotional stress: such as losing a job, a divorce, moving to a new location? If yes, please explain_____

_____

If a Physician referred you to our office, please list his/her name or list a Physician's name you would like us to send a report to.

Dr's Name_____

Address_____

_____ Patient Signature

_____ Reviewing Physician's Signature

Alpha Neurology PC

Patient Name_____Date of Birth_____Date_____

Reason for Today's Visit_____

Statistics:
Height_____
Weight_____
Right handed___ **Left handed**___

Current Medications:

_____
_____
_____
_____
_____
_____
_____
_____

NEUROLOGICAL
__**Dizziness**
__**Vertigo**
__**Memory loss**
__**Disorientation**
__**Speech or language dysfunction**
__**Inability to concentrate**
__**Seizures**
__**Taste, smell or touch disturbance**
__**Headache**
__**Migraine headache**
__**Numbness or Tingling**
__**General weakness**
__**Muscle weakness**
__**Slurred Speech**
__**Blurred vision**
__**Loss of consciousness**
__**Balance problems**
__**Falls**
__**Depression**
__**Neck pain**
__**Back pain**

CONSTITUTIONAL
__ Fatigue (sluggish, tired)
__ Weight loss
__Weight gain
__ Weight stable
__Night Sweats
__All negative

MUSCULOSKELETAL
__Muscle cramping
__twitching or pain
__Joint swelling
__Joint stiffness
__Joint pain
__Noise with joint movement
__Arm or leg pain
__All negative

SKIN
__Itching
__Scars
__Moles or lesions
__Changes in color of moles or lesions
__Rashes
__All negative

PSYCHIATRIC
__Anxiety
__sleep disturbance
__Hallucinations
__All negative
__Depression

CARDIOVASCULAR
__Chest pain
__Palpations
__Heart Murmur
__Irregular pulse
__High blood pressure
__Low blood pressure
__Swelling
__Coldness/numbness in fingers or toes
__All negative

EYES
__Itching
__ Excessive tearing
__Double vision
__Light sensitivity
__All negative

RESPIRATORY
__ Difficulty breathing
__ Chronic cough
__ Asthma
__Bronchitis
__All negative

GENITOURINARY
__Painful urination
__Frequent Urination
__Night urination
__Unable to control urination
__All negative

ENDOCRINE
__Diabetes
__Adrenal problems
__Changes in height or weight
__Increased appetite
__Increased thirst
__Hair change/loss
__All negative

HEMATOLOGIC/LYMPHATIC
__Anemia
__Bleeding tendencies
__Easy bruising
__Fatigue
__Recurrent infections
__Slow healing from cuts
__All negative

ALLERGIC/IMMUNOLOGIC
__Hay fever
__Itching
__Sneezing
__Chronic clear nasal drainage
__Conjunctivitis
__Allergies to Medication
__All negative

ENMT
__Sensitivity to noise
__Ear Pain
__Ringing in the ear
__Nosebleeds
__Sinusitis
__Vertigo
__Post nasal drip
__Bleeding gums
__Hoarseness
__Difficulty Swallowing
__All negative

GI
__Frequent heartburn
__Nausea
__Vomiting
__Constipation
__ Diarrhea
__Bloating
__All negative

_____ _____
Patient Signature HealthCare Provider Signature