CHRISTOPHER CHEN, M.D., INC.

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AME Intake

Type of Appointment: AME AME RE-EVALUATION

PLEASE FILL OUT ENTIRE FORM AND TYPE OR PRINT LEGIBLE

(if a field does not apply to you please indicate with n/a; so that the intake is still complete)

CLAIM No.:	Date of Request					
Name of Person Completing Intake:		Phone No.:				
Requesting Apt. on Behalf of (Check One):	Applicant's Atty. Defense Atty. Employee Adjuster	Location of Apt.	.:	PLEASANTON SACRAMENTO SAN MATEO PINOLE		
Certified Interpreter Required	Yes No	(If Yes, what language):				
Name of Certified Interpreting Service:		Phone No.:				
Which Party Will Arrange for Interpreter (Check One):	Applicant's Atty.	Defense Atty.	Adju	uster		
<u>PATIENT</u>						
Last Name:		First Name:			MI:	
Date of Birth:		Sex:	M	F		
SSN:						
Home No.:		Cell No.:				
Street Address						
City:		State:		Zip Code:		

Street Address:

INJURY							
Date of Injury:	Occupation at time of Injury:						
Body Part(s) Injured:							
Employer at time of Injury	Phone:						
Street Address:							
City	State:	Zip Code:					
INSURANCE CARRIER							
Adjuster Name:							
Insurance Carrier:							
Street Address:							
City:	State	Zip Code:					
Phone No.:	Fax No.:						
E-Mail							
APPLICANT'S ATTORNEY							
Attorney Name:							
Firm Name:							
Street Address:							
City:	State:	Zip Code:					
Phone No.:	Fax No.:						
E-Mail							
DEFENSE ATTORNEY							
Attorney Name:							
Firm Name:							

City:	State:	Zip Code:
Phone No.:	Fax No.:	
E-Mail:		

I've read the * Name of person submitting disclaimer below. (noted on page 3)

Optional Comments:

DISCLAIMER:

- NOTIFICATION OF APPOINTMENT:

Notification of appointment and a copy of these disclaimers/ AME policies are provided to the parties listed on the proof of service. We receive the information (names, addresses, fax numbers, etc.) from the rescheduling party and use that information to complete the proof of service. If they are inaccuracies in the proof of service or any documentation for the AME evaluation, please notify the office immediately.

- FAILURE TO APPEAR:

Appointment must be cancelled no later than two weeks prior to scheduled appointment. Failure to appear (patient or interpreter) will result in a no show fee of \$500.00. The party scheduling appointment is informed written and verbally of our cancellation policy at the time of the appointment is scheduled.

- CANCELLATIONS:

ONLY the scheduling party may cancel an AME appointment. Written documentation must be provided to cancel an appointment; verbal request are not accepted nor confirmation an appointment has been cancelled.

- MEDICAL RECORDS

To provide you with timely reports, we require records to be sent a minimum of 2 weeks prior to the scheduled appointment. If records are not received at least 72 hours prior to the scheduled appointment, the appointment may be rescheduled and a no show fee charged. If you are requesting our office to return medical records, you must provide a shipping label with the appropriate postage. We do not return records unless clearly noted in cover letter.

* SEND RECORDS AND CORRESPONDENCE TO (FOR ALL LOCATIONS):

4439 Stoneridge Drive, Suite 110, Pleasanton, CA 94588