

HANLEY PAIN & REHABILITATION CENTER, INC.

Allison W. Hanley, M.D.

Board Certified American Board of Internal Medicine
Diplomate American Academy of Pain Management
Certified Medical Review Officer

**SLIP & FALL REGISTRATION
(PLEASE PRINT)**

Today's Date: _____ Who can we thank for referring you? _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____
Last Name First Name Middle Initial

SS#: _____ Sex: Male Female Marital Status: Married Single Divorced Widowed

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Email: _____

Home Phone: _____ Work: _____ Cellular: _____

Is today's visit work related? Yes No Auto Accident? Yes No Date of Accident: _____

ATTORNEY INFORMATION

Law Firm Name: _____

Attorney Name: _____ Case Manager: _____

Address: _____

Phone: _____ Fax: _____

EMERGENCY CONTACT

Full Name: _____ Relationship to Patient: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____ Phone: _____

CONSENT FOR TREATMENT:

The undersigned hereby consent to the provision of examination, treatments, medical laboratory procedures, drugs, and supplies to the patient as ordered or requested by the patients' physician and acknowledges that no guarantee or assurance has been made as to the results of such treatments, procedures or examinations.

Patient Signature: _____ Date: _____
(PHOTOCOPY AS VALID AS ORIGINAL)

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SLIP & FALL ACCIDENT

Patient Name: _____ Date of Birth: _____

ACCIDENT INFORMATION

Accident Date: _____ Time: _____ AM PM

Where did the injury occur?

Location Name: _____

Address: _____

Was an incident report taken? YES NO

If yes, what is the:

Claim# _____

Adjuster Name: _____

Adjuster Contact #: _____

Did the police come to the accident site? YES NO

Was a police report filed? YES NO

Were there any witnesses? YES NO

In your words, please describe the accident (use back if needed):

PERSONAL INFORMATION

Were you aware or surprised by the impact? _____

Did any part of your body strike anything YES NO

If yes, please describe?

Did you have any pain or symptoms immediately after the accident? YES NO

Please explain: _____

Did paramedics come to the accident site? YES NO

Did the paramedics examine you? YES NO

Did you go to the hospital? YES NO

Which one? _____

From the accident site? YES NO

How did you get to the hospital?

Ambulance Self Other

At the hospital, what was performed?

X-rays CT Scan MRI Other

Were you prescribed medication? YES NO

Which Ones? _____

What were the hospital findings? _____

WORK INFORMATION

What do you do for work? _____

Please indicate your daily job duties:

Standing Sitting Walking Lifting Driving Twisting Crawling Bending Operate Equipment

Work with arms above head Typing Stooping Other: _____

Have you missed any work due to the accident? YES NO If yes, how many days? _____

While in recovery, is there any light duty work you can request? YES NO If yes, describe: _____

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Dear Patient:

Listed below are some of our most commonly used office policies and fees. We appreciate your cooperation and understanding of these guidelines.

Policies:

Our pain and rehabilitation services are separate from our Internal Medicine practice. We are not contracted with any group health insurances and may only bill your letter of protection given by your attorney.

We will only be able to provide you with care related to your slip & fall accident. If you need to establish with a primary care physician, we will gladly refer you to one.

Once you have reached a point of maximum medical improvement, you will be released from medical care. If you wish to return for treatments due to ongoing symptoms, your care will be strictly considered pain management and will require you to follow the self-pay pain management program. We will no longer be able to bill your letter of protection.

Self-pay patients: All payments for services rendered are required in full at time of service.

It is mandatory that all patient appointments have a 24-hour cancellation notice. All no-shows will result in a \$25.00 fee.

Please allow 48-hours for all prescription refills. Be aware that not all refills will be honored without an office visit.

Special Request Fees:

Completion of medically-necessary letters and forms (e.g. FMLA): \$25.00

Copy of medical records/billing records: \$25.00 for the first 25 pages, 0.25 per additional page.
(1 week notice is required. An additional fee will be charged if requested sooner)

I have read and understand the above policies.

Patient Name: _____

Patient Signature: _____

Date: _____