

BIONIC CHIROPRACTIC
108 E. Arctic Ave, Palmer, AK 99645

Dr. Joseph T. Hawkins, D.C.
745-HELP (4357)

WORKMAN'S COMPENSATION OFFICE POLICY

If you have been injured on the job, you should have workman's compensation coverage through your employer to cover chiropractic care and other types of medical treatment that would provide 100% coverage. There are a few instances in which the adjusting company sets a limit to the type of care that they will cover and other arrangements may have to be made in this case.

TREATMENT SCHEDULE

BIONIC Chiropractic and your workman's compensation adjuster have a common purpose; that is you - the claimant. Our goal is to return you to the good health you were in before your unfortunate injury. In order to reach our goal, we must all work together. We have found, through experience, that our patients obtain better results when they follow through with our established office policies regarding their claim.

REPORT TO EMPLOYER

You must be sure to report your injury to your employer as soon as you realize you have had an on-the-job injury. They will provide you with the required paperwork to open your claim. Our office has additional forms that will be necessary for you to fill out. Please be accurate and complete all questions. We must submit your claim to the Alaska Department of Labor, Workman's Compensation Board within a required time limit. In order for us to meet these requirements, we need your portion of the paperwork completed on your first visit.

PHYSICIAN CHOICE (check one)

- I have chosen Dr. Hawkins to be my primary care physician specifically for this injury and will inform him in writing should I choose to change my primary care physician.
- I have been referred by _____ for treatment.
- My Workman's Comp carrier does not cover chiropractic; therefore I am fully responsible for all charges.

CONTROVERTED

Many times workman's compensation claims are controverted (disputed by the employer or adjusting company) because of a noncomplying claimant. When your physician has prescribed a particular treatment program, it is important for you to follow his instructions exactly. If you do not, chances are your condition is not going to be corrected and you risk the possibility of such a controversy.

PATIENT IS RESPONSIBLE

In the event that your claim is controverted, you the patient become responsible for any unpaid balances. We will do all that we can to assist you in resolving your controversy, however we need a commitment from you that you are seeking some form of action to remedy the situation and that you will keep us informed of your progress. At the time you are notified of a controversy, please see the workman's compensation accounts clerk for more information and to work out other arrangements for you.

SUPPLEMENTS AND SUPPORT

Your workman's compensation insurance may not cover everything necessary to treat your condition properly. Any nutritional supplements, or other supplies are to be paid for by you at the time of purchase. In the event that your insurance company does cover these types of items and pays us for them also, you will be reimbursed by us for your payment.

It will be necessary for you to follow through with your recommended treatment program. We request that you call in advance if ever you find it necessary to re-schedule an appointment and that you make up that appointment as soon as possible. A certain number of treatments within a set amount of time is required for us to get the results we both desire.

I have read and fully understand BIONIC Chiropractic workman's compensation policy. The information regarding my injury that I have provided for you is complete and accurate to the best of my knowledge.

PATIENT SIGNATURE

DATE

W/C ACCOUNTS CLERK

DATE

PATIENT INFORMATION

Patient's name: _____ Home phone #: _____
Last First M.I.

Cell Phone: _____ Text Reminder ___ Yes ___ No Cell Phone Carrier: _____

Mailing address: _____
City State Zip

Male ___ Female ___ Birthdate: _____ Age: _____ S.S.#: _____

Driver's License #: _____ If other than AK, what state? _____

Marital status: M ___ S ___ W ___ D ___ Seperated ___ Spouse's name: _____

How did you hear about us: _____ Sign _____ Newspaper _____ Phonebook
Perhaps a friend or a relative referred you into our office. Please include their name so we can properly thank them.

INJURY DATE: _____ DATE LAST WORKED: _____

Have you reported your injury to your supervisor? ___ YES ___ NO

Have you filled out an injury report for Worker's Compensation from your employer? ___ YES ___ NO

Was body part injured before? ___ YES ___ NO

If yes, when. _____ Please describe: _____

Have you seen any other doctor for this injury? ___ YES ___ NO

If yes, list name and address: _____

Describe injury and tell how it happened: _____

Were you hospitalized as an inpatient? ___ YES ___ NO

If yes, name of hospital: _____

Date you were seen: _____

Occupation: _____

Employer: _____ Work phone: _____

Employer's address: _____
City State Zip

If known, Worker's Compensation insurance carrier: _____

If known, Workers' Compensation claim number: _____