



TRISTATE PAIN INSTITUTE

1510 E WAGON WHEEL LANE FORT MOHAVE, AZ 86426

Phone: (928)788-3333 | Fax: (928)788-3555 | Email: INFO@TSPAIN.COM

HIPAA COMPLIANT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

****Entire form must be completed to be considered valid****

PATIENT INFORMATION:

Name of Patient / Previous Names

Birth Date

Phone Number

Street Address

City, State, Zip Code

AUTHORIZES:

RELEASE TO:

Name of Health Care Provider / Plan / Other

TRISTATE PAIN INSTITUTE

1510 E WAGON WHEEL LANE STE 110
FORT MOHAVE, AZ 86426

Street Address, City, State, Zip Code

(928)788-3333

(928)788-3555

Phone

Fax

Phone

Fax

INFORMATION TO BE RELEASED: _____

Purpose of disclosure: I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans, or health care clearinghouses, which must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re0-disclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

1) I understand this consent may be revoked at any time, with the exception and to the extent that disclosure of this information has already occurred prior to the receipt of revocation by the above named provider. 2) I understand if written revocation is not received, this authorization will be considered valid for a period of time not to exceed 12 months from the date signed. To initiate revocation of this authorization, I must submit my request in writing to the "authorizes" entity above. 3) I understand a photocopy of this authorization is to be considered as valid as the original. 4) I understand the information used or disclosed pursuant to this authorization may be transmitted electronically and may be subject to re-disclosure by the recipient and may no longer be protected by Federal Law. 5) I understand that I have the right to refuse to sign this authorization, am signing this authorization voluntarily, and that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization. 6) I have the right to receive a copy of this authorization and any records obtained with its use. 7) I understand this consent includes disclosure of: Alcohol, Drug Abuse, and/or Psychiatric records, Sexually Transmitted Disease, and HIV/AIDS information. 8) I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information, or obtain copies of my health information, by contacting the Privacy Officer.

Expiration Date: This authorization is good until the following date(s) _____ or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately meets my wishes.

Signature of Patient or Legal Representative: _____ **Date:** _____

_____ If signed by other than the patient, provide documentation.

TRI STATE PAIN INSTITUTE
Benefits Assignment and Financial Responsibility

First Name _____ Last Name _____

DOB: _____ SSN: _____

Address: _____

City, State, Zip: _____

Release of Information: I authorize TriStat Pain Institute to disclose and release information to my insurance carrier(s), including Medicare, VA ,TriCare, Medicaid, Medigap ,Supplemental benefit providers, and private insurers,as applicable, any medical and treatment information needed for payment purposes for services rendered.. I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorized my provider/practice to act as my agent in helping obtain payment from my insurance companies.

Assignment of Benefits: I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to my provider or practice for services rendered. I understand I will receive a statement for any balance due by my and I agree to make full payment upon receipt of the statement after insurance has met its obligation.

Agreement of Responsibility: I understand that copayment is due at the time of service (coinsurance and deductibles may also be collected at the time of service). I understand I am financially responsible for charges not covered by my insurance company. I also agree to pay any outstanding balance as well as attorney fees and costs to TriState Pain Institute if this matter is referred to collection.

Medicare Authorization: If a Medicare beneficiary, I understand my signature requests payment to be made and authorize the release of medical information necessary to pay claims. If “ other health insurance” is indicated in item 0 of HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes the release of information to insurance companies or its authorized agents. In Medicare- assigned cases, the physician or supplier agrees ot accept the charge of determination of the Medicare carrier as the full charge, and I agree I am responsible for deductible ,coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Patient Signature: _____

Date: _____

Printed Name: _____

Tri-State Pain Institute

INJECTION CANCELLATION POLICY

At Tri-State Pain we are aware of the pain our patients are in and want to get you the relief you need . We understand the large demand for injections and due to several cancellations and no show appointments taking up valuable space on the schedule, we have had to implement a Cancellation Policy for injections.

We are requiring notice of the canceling or rescheduling of an appointment 24 hours in advance. If a call is made on a Saturday or Sunday, this will not be considered a cancellation as our office is not open during that period of time. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you have prevented another patient from getting much needed treatment.

If you miss an appointment and do not cancel in advance , there will be a \$50.00 no show fee assessed to you.

The charge is not billable to your insurance and we will not reschedule the injection until the payment has been paid.

I have read the cancellation policy for TriState Pain and understand by signing and date below, I acknowledge my understanding and acceptance of this policy.

Name

Date

Signature

TRISTATE PAIN INSTITUTE PATIENT AGREEMENTS

I agree to take the medication only as prescribed. I understand that these drugs can be very useful, but have a high potential for misuse and are therefore closely controlled by the local, state, and federal government. Because my physician/health care provider is prescribing such medication to help manage my pain, I understand the risks associated with them.

Physical dependence is common to many drugs such as blood pressure medications, anti-seizure medications, and opioids. It results in biochemical changes such that abruptly stopping these drugs will cause a withdrawal response. It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.

Addiction is a primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life. If the patient exhibits such behavior, the drug will be tapered and such a patient is not a candidate for an opioid trial. You will be referred to an addiction medicine specialist.

Tolerance means a state of adaptation in which exposure to the drug induces changes that result in a lessening of one or more of the drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a realistic decrease of the patient's pain.

I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my physician/health care provider at TriState Pain Institute; unless emergency care has been provided, if so please contact our office.

There are side effects with opioid therapy, which may include, but not exclusively; skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental health) and/or motor ability. Overuse of opioids can cause decreased respiration. It is my responsibility to notify my physician/health care provider of any side effects that continue or are severe (i.e., sedation, confusion). I am also responsible for notifying my pain physician immediately if I need to visit another physician or need to visit an emergency room due to pain, or if I become pregnant.

Validation of Correct Medication Management is required regularly and randomly as needed, including drug testing patients and random pill counts. There are no exceptions. Urine screening is the most common source of specimens, but blood can also be used. TriState Pain Institute reserves the right to observe you while the specimen is obtained. Substituting or tampering with the specimen in a deceptive manner constitutes grounds for termination. Should you be unable to provide a specimen when requested, you are responsible to return no later than 24 hours to do so.

I have been informed and understand the policies regarding the use of controlled substances by TriState Pain Institute, its providers, and staff. I acknowledge that I will only be prescribed controlled substances if they are deemed medically necessary based upon a valid diagnosis.

Received and Read: _____ Date: _____

Printed Name: _____

TRISTATE PAIN INSTITUTE

PAIN MANAGEMENT PHILOSOPHY AND PRACTICE

As a patient of TriState Pain, you can expect the following: Evaluation of you as a Chronic Pain Patient - Evaluation of your pain will initially include a pain history and assessment of the impact of pain on you, a directed physical examination, a review of previous diagnostic studies, a review of previous interventions, a drug history, and an assessment of coexisting diseases or conditions.

Treatment Plan - Treatment planning will be tailored to both you as an individual and the presenting problem. Consideration will be given to different treatment modalities, such as formal pain rehabilitation program, the use of behavioral strategies, the use of non-invasive techniques, or the use of medications, depending upon the physical and psychosocial impairment related to the pain. An opioid trial will not be initiated in the absence of a complete assessment of the chronic pain complaint. Opioids will not be prescribed on the first patient visit unless there are extreme extenuating or acute care reasons.

Informed Consent - Your physician must discuss the risks and benefits of the use of controlled substances with you, persons you designate or with your surrogate or guardian if as a patient you are without medical decision making capacity. This discussion will include the risks of addiction/abuse, not alleviating all or your pain, and treatment alternatives including the effects of no treatment.

Agreement for Treatment - There are circumstances in which the use of a documented verbal or written agreement between physician and patient outlining your responsibilities as a patient may be necessary for safe and responsible opioid prescribing. Such an agreement will include urine /serum medication levels and baseline screening when requested; number and frequency of all prescription refills; reasons for which drug therapy may be discontinued (e.g., violation of agreement) requirement that the patient receive all controlled substance prescriptions from one physician and one pharmacy whenever possible. You have received several documents with information regarding opioid I controlled substance treatments and the risks associated. These documents include the rules and terms of such treatment while you are a patient of TriState Pain.

Consultation - Consultation with specialist in addiction, psychiatry or with a psychologist may be warranted, depending on the complexity of the presenting problem. The management of chronic pain in patients with a history of addiction or a comorbid psychiatric disorder requires special consideration, but does not necessarily contraindicate the use of opioids.

Controlled Substance Prescription Drug Monitoring (PMP) -The Arizona Controlled Substance Prescription Drug Monitoring Program's (PMP) mission is to reduce pharmaceutical drug diversion while promoting legitimate medical practice and patient care. PMP data accumulates Schedule II through IV controlled substance prescription and dispensation information for facilitating diversion awareness and intervention. It is assumed prescribers and pharmacists dedicate their professional skills to identify and assist controlled substance abusers. Prescribing practitioners and dispensers must treat this information in accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and applicable state law. This includes accessing and checking the PMP on each patient for multiple providers prescribing to the patient, or multiple pharmacies being used to fill prescriptions. These can be signs of co-prescribing, diversion or abuse. Law enforcement users must obtain, use and share this information with criminal justice partners only in conjunction with criminal investigative matters. This data shall not be disclosed, sold, or transferred. All of our patients will be monitored through this program on a monthly basis. We also utilize the Nevada PMP Aware and California CURES prescription drug monitoring databases and will be able to see your activity at different pharmacies, as well as prescriptions given by other doctors We may access the PMP of any state. A copy of your PMP will be printed and scanned into your medical records at each visit. If you are in violation of your contract, you may be discharged from our clinic.

INITIALS: _____

TRISTATE PAIN INSTITUTE

Pain Treatment with Opioid Medications: Patient Agreement

Please review the information listed here. Do not sign if you have any questions or concerns regarding any of this, and ask a provider or member of the TriState Pain Institute for clarification.

I understand and voluntarily agree that:

I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

I understand that prescriptions may be filled only during scheduled office visits with the treatment team.

I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

I understand, currently prescriptions are prescribed electronically to the pharmacy. There are no written prescriptions.

I agree that if I am under the care of another provider, and that provider prescribes me a benzodiazepine, I could suffer from significant side effects or death as a result of the combination of opioid and benzodiazepines. I understand that TriState Pain may not agree to treat me with opioids if I am taking benzodiazepines without the co-management and cooperation of my care team, especially other prescribing physicians.

Notification of Office Reminders and Related Information:

Phone Message/Call Authorization (means of communication via phone, fax, or email) " I, the undersigned, hereby authorize the staff of Tri-State Pain to leave messages on my answering machine or cell phone regarding my care or for appointment reminders or transmission of other information via fax, text or email."

IF I HAVE ANY QUESTIONS, I WILL ASK STAFF

Received and read: _____ Date: _____

Printed name: _____

**TRI-STATE MEDICAL SPECIALISTS LLC D/B/A TRISTATE PAIN INSTITUTE
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY MEMBER
OR FRIEND**

I authorize the use and/or disclosure of my health information as described below. I understand that this authorization is voluntary. I also understand that the person authorized to receive the information is not a health plan or healthcare provider, the released information may be re-disclosed and may no longer be protected by the federal privacy regulations.

Patient providing Authorization (PLEASE COMPLETE IN FULL)

Patient Name: _____ Date: _____

Date of Birth _____

The person listed below is authorized to access my medical information:

Name: _____ Relationship: _____

Additional Person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize Tri-State Medical Specialists LLC d/b/a TriState Pain Institute to disclose/release the following information:

All medical records including UDS and mental health , All billing records related to (specify condition, treatment, etc.): ____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. Also, I understand that I do not need to sign this Authorization to receive treatment. I also am aware that I may revoke this Authorization by notifying the TriState Pain Institute in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed under this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

Signature of Patient or Personal Representative

Date

PATIENT INTAKE WORKSHEET

Patient Name: _____ DOB: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ OR: _____

E-Mail Address: _____ Social Security: _____

EMERGENCY CONTACT : _____ PHONE: _____

DO YOU HAVE AN ADVANCE DIRECTIVE/POWER OF ATTORNEY/LIVING WILL IN PLACE? YES NO

IF YOU WOULD LIKE TO ADD A COPY TO YOUR CHART, PLEASE GIVE TO FRONT DESK.

INSURANCE INFORMATION:

NAME : _____ ID#: _____

SUBSCRIBER NAME: _____ RELATIONSHIP: _____

SUBSCRIBER DOB: _____ SUBSCRIBER SSN: _____

DO YOU HAVE WORKMAN'S COMPENSATION ? RECENT MVA THAT YOU ARE TREATED UNDER ?

Pharmacy : _____

PBM CONSENT- provides the physician with information about medication that you are already

prescribed by any provider, to minimize the number of adverse drug events.

Printed Name: _____

Signature: _____

THE TRI STATE PAIN INSTITUTE

CONSENT TO TREAT AND AUTHORIZATION TO RELEASE INFORMATION

I consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the attending physician. I authorize TriState Medical Specialists, LLC to furnish my Insurance carriers information regarding history, physical findings and treatment rendered as allowed by HIP AA. I further authorize any holder of medical or other Information about me to release such information to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare I other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment or medical insurance benefits to the party who accepts the assignment.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I request and authorize that payments for authorized Medicare I other insurance company benefits be made directly to TriState Medical institute, LLC on my behalf. This includes all services furnished to me by TriState Medical Specialists, LLC, by whomever accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I also understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 11288 of the Social Security Act and 31 USC. 380 1-3 812 provides penalties for withholding this Information).

PATIENT RESPONSIBILITY

I agree that I am responsible for all charges incurred in this office, if my insurance coverage does not provide full benefits. I will pay any patient responsibility balance due within 30 days unless I have made other arrangements with TriState Medical Specialists, LLC. If cancellation of my appointment becomes necessary, I will contact Tri-State Medical Institute, LLC no later than twenty- four (24) hours prior to my scheduled appointment time. I understand that failure to follow the cancellation of appointment policy, I may be subject to a charge of fifty dollars (\$50.00) and such charge is not payable through my insurance. I have read the TriState Medical Specialists, LLC Office Policy Statement and all my financial questions were answered.

ANCILLARY SERVICES

As a convenience to our patients, TriState Medical Specialists, LLC offers direct dispensing of medications, topical creams, durable medical equipment, as well as on site diagnostic testing as recommended. I understand I am under no obligation to obtain these pharmaceuticals, orthotics, or services through TriState Medical Specialists, LLC, and at any time can request a referral to an independent pharmacy, medical supply outlet, imaging center, hospital or another provider.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of all medical I surgical benefits to TriState Medical Specialists, LLC (dba TriState Medical Institute), for services rendered to them in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance. I also authorize my doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have been provided the Tri-State Medical Specialists LLC d/b/a TriState Pain Institute's Notice of Privacy Practices ("Notice"):

It tells me how Tri-State Medical Specialists LLC d/b/a TriState Pain Institute will use my health information for my treatment, payment for my treatment, and its health care operations.

The Notice explains how TriState Pain Institute may use and share my health information other than treatment, payment, and health care operations.

The organization will also use and share my health information as required/permitted by law.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize TriState Medical Specialists, LLC (dba TriState Pain Institute) to release any medical or incidental information that may be necessary for either: (1) medical care, or (2) processing applications for financial benefits.

Patient Name: _____

Patient Signature: _____ Date: _____

MY MEDICATIONS, ALLERGIES AND FAMILY HISTORY

I currently take the following medications for PAIN and related complaints :

Tylenol /Codeine MS Contin Suboxone Naprosyn Flexeril Gabapentin Hydrocodone
Dilaudid Subutex Mobic Cymbalta Zohydro Methadone Fentanyl Patch Celebrex Valium
Lyrica Oxycodone Opana Butrans Patch Diclofenac Zanaflex Tegretol OxyContin Opana ER
 Tramadol Indomethacin Xanax Dilantin Morphine Kadian Motrin/Ibuprofen Advil /
Aleve Ativan Topical Cream Other:

LIST ALL **NON-PAIN** RELATED **DAILY** MEDICATIONS {Name, Dose, and how often you take the medication):

BLOOD THINNERS (circle): Aspirin (81 mg 325mg) Plavix Coumadin Xarelto Other :

MEDICATION/ FOOD ALLERGIES {List Medication and Reaction):

PLEASE LIST ALL DISEASES THAT RUN IN YOUR FAMILY:

I AM ADOPTED

MY MEDICAL HISTORY

PLEASE CIRCLE ALL THAT APPLY:

CARDIOVASCULAR: Hypertension Cholesterol MI Aneurysm Heart Failure PAD

Carotid Disease LE Edema Pacemaker On Blood Thinners Chest Pain Palpitations

LUNGS: COPD Asthma Pneumonia Valley Fever Asbestos Bronchitis Shortness of Breath

GASTROENTEROLOGY: GERD/PUD Irritable Crohn's Disease Gallbladder Diverticulitis

Constipation Hemorrhoids Pancreatitis Bowel Obstruction Liver Disease

GU/RENAL: UTI Kidney Stones Renal Failure /Dialysis? Y N Bladder Disease

MALES: Prostate Hypertrophy Erectile Dysfunction **FEMALES:** Stress Incontinence

ENDOCRINE: Diabetes: Insulin Meds Osteoporosis Thyroid Hypo Hyper Low T

NEURO: Stroke Seizures Tremor Essential Parkinson's HA/Migraine MS Dementia

Hydrocephalus Neuropathy ALS RSD CRPS Restless Leg Syndrome

GYN: Periods Reg Irreg. Post-Menopause Menopause Perimenopause Hysterectomy

CANCER : _____ In Treatment In Remission Metastatic Disease

RHEUM; Rheumatoid Arthritis Osteoarthritis Lupus Fibromyalgia Raynauds

PSYCH: Depression Anxiety Bipolar Schizophrenia PTSD Decreased Libi

INFECTION: HIV MRSA Chronic Infection Hepatitis AIDS

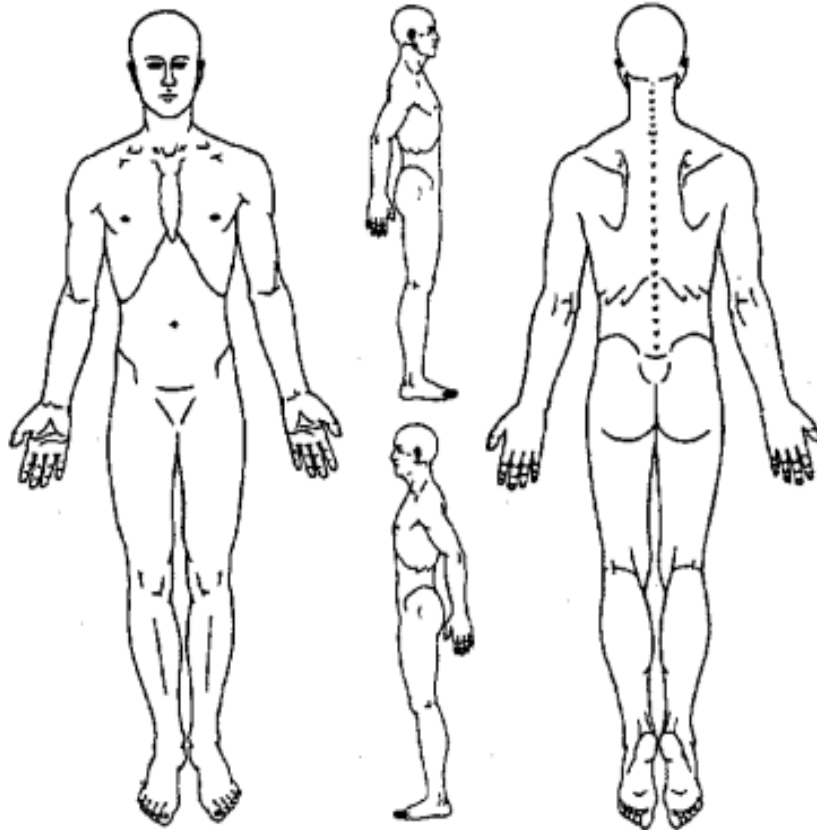
SENSORY : Glasses {Reading Only} Cataracts Glaucoma Hearing Loss Ringing in Ears Legally Blind

Double Vision Loss of Smell

OTHER:

Pain Diagram

Please mark the area of injury or discomfort on the body below:



What are you seeing the Doctor for today?

PAIN HISTORY

PAIN RELATED INTERVENTIONS/ OPERATIONS (CIRCLE PLEASE):

HEAD: Trigeminal injection Occipital Nerve Block TMJ Injection Suboccipital Stimulator

NECK: Epidural Facet Injections Trigger Point Injections Radiofrequency ("Nerve Burn")

Stimulator Surgery

THORACIC: Epidural Facet injections Trigger Point Injections Radiofrequency ("Nerve

Burn") Stimulator Surgery

BACK: Epidural Facet injections Trigger Point Injections Radiofrequency {"Nerve Burn")

Stimulator Surgery Drug Pump

JOINT: Shoulder Elbow Wrist/Hand Hip Knee Ankle

OTHER:

SOCIAL HISTORY

Marital Status: _____

Vocational: Work Unemployed Retired Disabled

Abuse: Spousal Physical Verbal Emotional PTS Syndrome

Smoking Tobacco: Age Started? _____ Year Quit? _____ PPD: _____

Vape: Age Started? _____ Year Quit? _____

Chew Age Started? _____ Year Quit? _____

Alcohol: Yes No How often? _____ Are you an alcoholic? Yes No

Drugs: Meth Cocaine Heroin Other _____

MY SURGICAL HISTORY

PLEASE CHECK ALL THAT APPLY

SPINE: Cervical Lumbar Fusion Thoracic Scoliosis Vertebroplasty

Stimulator Drug Pump SI Fusion

ORTHO: Shoulder Elbow Wrist/Hand Hip Knee Ankle/Foot Carpal Tunnel

Ulnar Nerve Release Fracture Surgery

HEAD: Craniotomy Aneurysm Coiling Shunt DBS Pituitary

EYES: Cataracts Glaucoma Surgery Detached Retina Lasik Vision Surgery

ENT: Thyroid Sinus Surgery Head / Neck Tumor Ear Surgery Vocal Cord Surgery

LUNG: Bronchoscopy Lung Biopsy Lung Resection Drainage of Lung Fluid

CARDIOVASCULAR : Heart Stent Coronary Bypass Surgery Cardiac Ablation

Pacemaker Carotid LE Stent Aortic Stent Renal Stent Femoral Stent

ABDOMEN: Appendectomy Gall Bladder Colon Resection Esophagus Stomach Trauma

Abdominal Surgery Hemorrhoid Pancreas Surgery Endoscopy

GYN: Hysterectomy Tubal Ligation



TRISTATE PAIN INSTITUTE

1510 E WAGON WHEEL LANE FORT MOHAVE, AZ 86426

Phone: (928)788-3333 | Fax: (928)788-3555 | Email: INFO@TSPAIN.COM

PATIENT NAME: _____ DOB _____

Please answer the following questions to the best of your knowledge.

_____ Yes, I do have an open Workman's Comp Case.

_____ NO, I do not have an open Workman's Comp Case.

If you answered Yes,

Date of injury and or loss _____

Name of Workman's Comp Company: _____

Name of Adjuster: _____

Adjusters Contact Information: _____

Patient Signature: _____ Date _____

** If your Medicare Insurance is showing an Open Workman's Comp Case and you have any questions, please call Medicare 1-800-633-4227 to update your Coordination of Benefits (COB).

** Commercial Insurance uses the phone number on the back of your insurance card for any information update.

**Tristate is here to help you with any questions that you may have.