www.workercareclinic.com

Patient Registration

Name _____

Date of Birth _____

Work Phone _____

Email _____

Cell Phone _____

How Did You Hear About Us?

☐ ER ☐ Urgent Care ☐ Primary Care ☐ Employer

☐ Friend/Family ☐ Attorney ☐ Internet Search

☐ Sign/advertisement ☐ Previous Patient

☐ Drug screen/physical exam/other service

☐ Other_____

Please complete if NOT filling out Report of Accident or Reopening Application today.

Claim # _____

Soc Sec # _____

Address _____

City _____ State _____ Zip _____

Employer of Injury_____

Occupation _____

Home Phone _____

❑ Married ❑ Single ❑ Separated

❑ Divorced ❑ Widowed ❑ Domestic Partner

Name of Husband/Wife/Partner _____

In Case of Emergency Contact

Name _____ Relationship _____ Phone _____

Local Personal Physician _____

Please read before signing:
I understand that I am financially responsible for all charges including, but not limited to, deductibles and services not covered by my insurance, regardless of coverage, and I agree to pay such charges. My signature below permits the release of all information necessary to secure payment of benefits from my insurance carrier. I understand that all laboratory, x-ray, and other testing performed by outside facilities and specialists will be billed directly to the patient by these facilities and specialists.

AUTHORIZATION: I hereby authorize the Doctor(s) and the medical staff of Yakima Care Worker to provide such medical services as may be determined to be in the best interest of the patient listed above.

I hereby authorize any holder of medical information about me to release any information needed to process my claim. I also authorize any insurance benefits to be made to Yakima Worker Care.

Our Notice Of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. By my signature below, I acknowledge receipt of the Notice Of Privacy Practices.

_____ _____

Signature of Patient or Legally Auth. Date

Medical History Form

Name_____

Date of Birth _____

General:

What activities and hobbies do you participate in on a regular basis? _____ _____

_____ _____ _____ _____

Who is your primary care provider (PCP)? _____

Do you have regular wellness checks? ❑ Yes ❑ No How often? _____

Have you ever had other work-related injuries? ❑ Yes ❑ No

Please list any reasons for which you have had surgery and/or gone to the hospital (give dates)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Have you ever had injuries to the following areas?

Neck ❑ Yes ❑ No Back ❑ Yes ❑ No

Knees ❑ Yes ❑ No Shoulders ❑ Yes ❑ No

Medications:

List all medications you are taking: _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Herbal / naturopathic treatment and/or medications: _____

_____ _____ _____ _____

Any allergic reactions to medication? ❑ Yes ❑ No List: _____

_____

Social history and habits:

Do you use tobacco? ❑ Yes ❑ No

If yes, ❑ Smoke ❑ Chew ❑ Plan to stop Number of years smoked _____ Packs per day _____

If no, ❑ Never used ❑ Quit in _____

Do you drink alcoholic beverages? ❑ Yes ❑ No

❑ Regularly (3+ times a week) ❑ Seldom /Occasionally

Do you use illegal or unprescribed medications? ❑ Yes ❑ No

Do you have a history of drug abuse or addiction? ❑ Yes ❑ No

Have you ever received treatment for drug/alcohol abuse? ❑ Yes ❑ No

Family History: Mark corresponding box for any family members with the following conditions.	Grand father	Grand mother	Father	Mother	Sibling	Child
Diabetes						
High Blood Pressure						
Heart Attack						
Stroke						
Epilepsy/Seizures						
Tuberculosis						
Cancer						
Alcoholism/Drug abuse/Addiction						
Depression						
Other Mental Health Issues						

Name_____

Date of Birth _____

SYSTEMS: Have you had the following issues?	No	Yes	For how long/ how long ago?	Explain
GENERAL				
Unexplained weight loss/gain				
Fever/fatigue				
Head injury/Traumatic brain injury				
List all cancers for which you have been diagnosed and/or treated (e.g., Lung, stomach/bowel, breast, cervical, prostate, etc.)				
EYES				
Color blindness				
Continuous blurring of vision				
Double vision				
Glasses/contacts				
Other eye problems (specify)				
EARS				
Hearing Loss				
Continuous ringing in ears				
Other ear problems (specify)				
NOSE/THROAT				
Hay fever				
Sinus troubles				
Sleep disorder (e.g., sleep apnea)				
Other problems (explain)				
Nose				
Throat				
Neck				
LUNGS/CHEST				
Continuous nagging cough/hoarseness				
Coughed up blood				
Wheezing				
Shortness of breath				
Asthma				
Pneumonia				
COPD				
Obstructive sleep apnea (Sleep disorder)				
Tuberculosis (TB)				
Scarring on chest x-ray				
HEART/BLOOD VESSELS				
Ankle swelling				
Chest pain				
Atrial fibrillation				
Irregular heart beat				

Name_____

Date of Birth _____

HEART/BLOOD VESSELS	No	Yes	For how long/ how long ago?	Explain
Heart attack				
Heart murmur				
High blood Pressure				
Stroke				
Elevated cholesterol				
Other heart or blood vessel problems (specify)				
HEMATOLOGY				
Hemophilia or bleeding disorder				
Clotting disorder				
Other blood dyscrasias (specify)				
GASTROINTESTINAL				
Difficulty swallowing or indigestion				
Unusual heartburn				
Vomited blood				
Change in bowel habits				
Cirrhosis				
Hepatitis (Yellow Jaundice)				
Gallbladder disease				
Ulcers				
Pancreatitis				
Colitis				
Diverticulosis				
Hemorrhoids				
Hernia				
Other GI problems (specify)				
URINARY				
Frequent Urination				
Getting up at night to urinate				
Kidney infections				
Kidney stones				
Bladder infections				
BONE/MUSCLE				
Joint aches				
Joint stiffness				
Fractures (Specify where)				
Chronic back pain				
Back disc disease				
Fibromyalgia				
Arthritis				
Other bone/muscle problems (specify)				

Name_____

Date of Birth _____

NERVOUS SYSTEM	No	Yes	For how long/ how long ago?	Explain
Headaches				
Seizures/epilepsy				
Other nervous system problems (specify)				
ENDOCRINE/GLANDULAR DISORDERS				
Thyroid problems				
Diabetes (circle responses below)				
Type 1 Type 2 controlled by: diet/exercise alone oral medication insulin injections				
Other endocrine problems (specify)				
Other immunosuppressive condition (specify)				
SKIN				
Lump or unusual thickening of skin				
Sore that does not heal				
Obvious change in wart or mole				
Other skin problem (specify)				
PSYCHOLOGICAL				
Anxiety disorder				
Depression				
Bipolar				
Schizophrenia				
Insomnia/sleep disturbance				
Other psychological issue (specify)				
MEN ONLY				
Prostate infection				
Prostate enlargement				
Testicle problem				
Other genital problems				
WOMEN ONLY				
Breast issues (lumps, etc.)				Date of last mammogram:
Uterus problems (e.g., Hysterectomy)				
Unusual bleeding or discharge				
Still having regular periods?				Date of last period:
Do you think you may be pregnant?				
Have you ever been pregnant?			#Pregnancies:	#Live births:

Patient Signature _____ Provider Signature _____ Date_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

PATIENT HANDBOOK

HOURS & CONTACT INFO

HOURS

M-F 8:00-5:00

YAKIMA CLINIC

409 S 12th Ave, Yakima

(509)575-2949

SUNNYSIDE CLINIC

1614 E Edison, Suite E, Sunnyside

(509) 836-0075

PATIENT HANDBOOK

THANK YOU FOR CHOOSING WORKER CARE.

We know you have other options and we will work hard to meet your needs. Our goal is to work with you in partnership to restore your health and help you continue to work. We will communicate with you, your employer and your claim manager to facilitate these goals.

Please take a few moments to review this handbook. In it, we have listed things patients will need to know as they go through the workers' comp process.

Please note that this handbook is not a guarantee of treatment, nor is it a contract. We reserve the right to change policies described here at any time, with or without notice.

PATIENT EXPECTATIONS

AS A PATIENT, YOUR MAIN JOB IS TO GET BETTER

We fully expect that you will participate in your treatment plan. For example, we expect you to:

- Attend all appointments scheduled, including those for therapy, specialist and surgical consults, and extra testing such as MRIs and CT scans;
- Follow dosing and usage instructions for medications; and
- Follow activity restrictions and home exercises.

During the healing process, you should expect to feel some pain. However, please let us know as soon as possible if this pain is too much to bear or if you feel your condition is worsening.

HOLIDAYS

We are closed on:

New Year Day
Memorial Day
Independence Day
Labor Day
Thanksgiving (Thurs & Fri)
Christmas Eve
Christmas Day

SCHEDULED APPOINTMENTS

You should receive a reminder call 1 to 2 days before your next appointment. Please make sure we have your current contact phone number. If you do not receive a reminder call, please let the staff know when you check in for your appointment.

It is your responsibility to show up on time for all scheduled appointments. If you know you will not be able to make it on time, please call at least a day before the appointment to reschedule. If you miss one appointment without notifying us, we will reschedule you for a time less requested by punctual patients. No-shows will be reported to your claim manager. If you are on any work restrictions, we will then complete an Activity Prescription Form (work restriction sheet) releasing you to full duty work, since you seem to be well enough to do other activities instead of showing up to your appointment.

DISMISSAL FROM PRACTICE

We do our best to maintain a professional, caring environment. We expect you, too, to behave and speak in an appropriate manner while at our clinic. Patients who engage in abusive behavior, verbal and/or physical threats may be asked to leave the clinic and reported to the claims manager and, if necessary, the local police.

Patients who refuse to follow the medical treatment plan given to them by their provider, and/or those who cannot control their behavior with staff and/or providers, will be given a written 30-day notice to find a new workers' comp provider.

CARE FOR CONDITIONS NOT COVERED BY THE CLAIM

YOUR HEALTH IS IMPORTANT!

If you don't have a "regular" primary care provider, please find one. We can only treat your work-related injury. Sometimes, we TEMPORARILY treat non-covered conditions if that condition makes it hard for your work injury to heal. If we attempt to get a new condition covered in your claim and it is rejected by the insurer, you will need to ask your primary care provider to treat that condition.

FINANCIAL RESPONSIBILITY

We do our best to ensure that services provided will be covered by your workers' comp insurer. There are times, however, when the insurer will deny payment and/or claims in their entirety. In these instances, you, the patient, will be responsible for any outstanding bills. We will work with you to bill your medical insurer and/or to make attainable payment arrangements.

MEDICATION REFILLS

If you need a medication refill, please notify your pharmacy at least 2 business days before you need the medication. The pharmacy will fax our clinic to request authorization of the refill. If you are told you need a hand-written prescription to get the refill, please remember to request it at your next appointment. We will not be able to refill medicine if we believe you should no longer use it, or if the medication should be managed by your non-workers' comp primary care provider.

If you have not been keeping your appointments, we will not be able to refill your medication until you are seen again in our office. We need to check in person how well this medication is working, even if you have been using it for a while.

PAIN MEDICATION

There are times when opioid (narcotic) pain medication may be needed to help you deal with pain due to a work-related injury. When we prescribe an opioid, you will be expected to complete a urine drug screen and complete an opioid contract that spells out the side effects and use of opioids. We normally will not prescribe opioids after completion of the first two weeks following your injury. Under unusual circumstances where more prolonged opioid use is needed, we will only prescribe opioids if they improve your function and decrease your pain level. If you believe the only way you can function is with opioids, you will need to see your primary care provider to manage your chronic pain outside of the claim. We will continue to help treat you for other parts of the claim until the claim is resolved.

AUTHORIZATION FOR SPECIALIST APPOINTMENTS OR EXAMS

Workers' comp insurers require pre-authorization for imaging, procedures, exams and treatment by specialists and surgeons. When your provider orders such a service for you, we will seek authorization and then send a referral to the specialist's office. Sometimes this happens very quickly, but other times the process takes several weeks. The specialist or we will contact you to make an appointment. If you do not agree with a denial of services or feel the authorization process is taking too long, we encourage you to contact the claims manager for your workers' comp insurance.

TIME LOSS NOTIFICATION AND LOSS OF EARNING POWER (LEP)

Our preference is that you return to work on light duty or full duty when possible. This is the goal of treatment and the best outcome for everyone involved.

If you have been placed on light duty and you are getting paid less than your regular wage, you may be eligible for Loss of Earning Power benefits. Please contact your claims manager to initiate the process. If you are off work due to your work-related injury or if there is no light duty accommodation by your employer, you may be eligible for time loss benefits. The Activity Prescription Form (APF) will be the notice to the claim manager regarding this need.

EMERGENCIES

If your injury is suddenly much worse during office hours (8 AM to 5 PM Monday to Friday), please call the office for an urgent visit. After hours, please go to the nearest emergency department for help if needed. If in doubt regarding your safety or ability to make it to the Emergency Department, call 911.

FRIENDS AND FAMILY

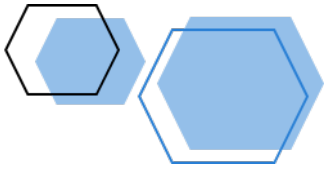
We want to make the most of our appointment time with you. Having children, family members, and/or friends in the room with you can distract your attention and make it difficult for the provider and other staff to effectively treat you. Therefore, unless you need another adult with you to help you with day to day activities or to drive, please make arrangements to come to your visits alone. If you are the primary caregiver of your children, please arrange for them to stay at home or with another responsible person, as our facility is not equipped for childcare.

In any of the above circumstances, if your companion(s) become(s) a distraction, they will be asked to leave and/or you will be asked to reschedule your appointment.

We will not discuss your case with friends and family members, so all phone calls on your behalf must be made by you, the patient.

PRIVACY

Workers' comp claims involve you, the insurer and their representatives, and your employer. We respect your privacy and use HIPAA compliant software and limit information to the extent it is feasible. However, workers' comp rules require us to share chart notes, paperwork and x-ray and test results with the parties listed above. You may request a complete copy of your claim file from your workers' comp insurer (Washington L&I even has an online portal you may use). If you would like a copy of our notes, we can provide that to you in an electronic format (CD or thumb drive) upon your request.



Patient Handbook Receipt

I, the undersigned, acknowledge that I have received a copy of the Patient Handbook for Worker Care. While I understand that the Patient Handbook is neither a contract nor a legal document, I recognize that it is my responsibility to read and understand the policies, provisions, and procedures contained in the Patient Handbook. I understand that if I have any questions and/or need clarification for items addressed in the Patient Handbook, it is my responsibility to contact Worker Care to discuss.

Yo, el abajo firmante, reconozco que he recibido una copia del Manual para pacientes de Worker Care. Entiendo que el manual no es un contrato ni un documento legal, pero reconozco que es mi responsabilidad leer y comprender las políticas, disposiciones y procedimientos contenidos en el manual para pacientes. Entiendo que si tengo alguna pregunta y/o necesito una aclaración sobre lo escrito en el manual, es mi responsabilidad contactar a la oficina de Worker Care.

Signature/*Firma*

Date/*Fecha*