128 Southland Dr., Suite 110
Lexington, KY 40503

Work Injury Patient Registration

PLEASE PRINT CLEARLY

PATIENT INFORMATION

Last Name: ____________________ First Name: ____________________ Middle Initial: _______

Date of Birth (month/day/year): __________________ Social Security Number: ____________________

Street Address: ____

City: ____________________ State: _________ Zip Code: ___________________

Primary Phone Number: ____________________ Alternate Phone Number: ____________________

Email: ____

Parent or Legal Guardian Name (if applicable): ____

Primary Language Spoken, if NOT English: ____

Marital Status: ◯ Married ◯ Unmarried Sex: ◯ Male ◯ Female

Spouse Name (if applicable): ____________________ Spouse Phone: ____________________

Employer Name: ____________________ Employer Phone: ____________________

Supervisor Name: ____________________ Supervisor Phone: ____________________

Description of Work Injury: ____

Original Date of Work Injury (month/day/year): __________________________

Does Your Employer Require That You Complete A Post-Accident Drug Screen: ◯ Yes ◯ No ◯ Unknown

While you are under no obligation to do so, do you authorize a nurse case manager or employer representative to accompany you during your exam? ◯ Yes ◯ No

If yes, please provide name of the individual here:____

____

EMERGENCY CONTACT INFORMATION

Please check here if your spouse is your primary emergency contact: ◯

For all others, please complete the following primary emergency contact information:

Contact Name: ____________________ Contact Phone: ____________________

(please complete the form on back)

Redpoint MEDICAL PSC
128 Southland Dr., Suite 110
Lexington, KY 40503

Work Injury Patient Consent

CONSENT FOR TREATMENT

I hereby voluntarily consent to medical services provided by Redpoint Medical, PSC and its healthcare providers and staff. I understand that these medical services may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical treatment; routine laboratory procedures and tests; prescribed x-rays and other imaging studies; administration of medications; and additional procedures and treatments that may be prescribed by Redpoint Medical PSC's healthcare providers.

I understand that there are certain hazards and risks associated with all forms of treatment, and my consent is given knowing this. I acknowledge that while every effort will be made to keep risks and side effects to a minimum, complications can be unpredictable both in nature and severity, and may occur.

I understand that I may be asked to sign a separate informed consent form for certain treatment(s) that require such consent.

As part of the medical procedures or tests conducted by Redpoint Medical PSC's healthcare providers and staff, I consent to be tested for human immunodeficiency virus (HIV) infection, hepatitis, or any other bloodborne infectious disease for purposes directly related to my medical treatment. If a healthcare worker is exposed to my blood or bodily fluids, Redpoint Medical, PSC may, at its cost, test my blood for any infectious disease. Redpoint Medical, PSC shall confidentially maintain to the extent provided by applicable law: a) the fact that a blood test was ordered, and b) the results of such tests.

I understand that this consent is valid and remains in effect until I withdraw my consent, which may be done in writing at any time or until Redpoint Medical, PSC asks me to complete a new Work Injury Patient Consent form.

I understand that if this consent is being signed on behalf of a minor, this consent is valid until the parent or legal guardian withdraws consent in writing, or until the minor turns 18, at which time the minor must consent for services on his/her own behalf.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

A copy of Redpoint Medical's "Notice of Privacy Practices" has been offered today for my review. I understand The Notice details various rights granted to me, the patient, under the Health Insurance Portability and Accountability Act, commonly referred to as HIPAA. I further acknowledge, however, that HIPAA defers to state law regarding disclosures of patient information for worker's compensation claimants and medical providers. Per Kentucky law, an employee who reports a work injury or who files for workers compensation benefits must "execute a waiver and consent of any physician-patient, psychiatrist-patient, or chiropractor-patient privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation." KRS 342.020 (8). Kentucky law further states that once The Medical Waiver and Consent (Form 106) is signed, any healthcare provider "shall, within a reasonable time after written request by the employee, employer, workers' compensation insurer [or its agent or assignee], special fund, uninsured employers' fund, or the administrative law judge, provide the requesting party with any information or written material reasonably related to any injury or disease for which the employee claims compensation." I understand and consent that Redpoint Medical, PSC may use and disclose my health information pursuant to Kentucky law(s) relating to worker's compensation and for the purposes of treatment, payment, and healthcare operations as outlined in The Notice provided to me today.

My signature below certifies that: a) the information I have provided on The Work Injury Patient Registration form (page 1) is correct to the best of my knowledge, and b) I have read and fully understand and consent to each section detailed above in This Work Injury Patient Consent form (page 2).

Signature: ____ **Date:** _________________________