111 W KY 80
Suite B
Somerset, KY 42503
Phone: 606.677.0101

1795 Alysheba Way
Suite 2101
Lexington, KY 40509
Fax: 606.268.6454

Designation of Individual(s) Authorization Release

I hereby authorize the designated parties listed below to request and receive the release of any health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the designated individual(s) must be verified before the release of any information. I understand that I have the right to withdraw this release at anytime.

AUTHORIZED INDIVIDUAL(S):

Name: _____ Relationship:_____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name: _____ Date: _____

Patient/Parent/Guardian Signature: _____ Date: _____

Consent Form

Patients are prohibited from using cell phones in our office due to federal privacy rules and/or unauthorized photography of our patients. Patients are strongly encouraged to valuables at home or with an accompanying family member or friend because this facility shall not be liable for the loss of or damage to any personal property, including but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents, or any other items.

Your signature on this document fully authorizes our staff and doctors to perform any examination, diagnostic tests, and/or treatments that we consider medically necessary and to release all information to your health insurance, or benefits to and all applicable parties. Our staff is committed to providing all patients regardless of race, color, national origin, age, sex, disability, religious, or political beliefs. Quality health services will be delivered with dignity and concern. HIPPA requires that we have had you read and sign the federally governed Health Care Privacy Notices. Your signature on this document confirms that you have read, understand, and agree to comply with all the terms and conditions of HIPPA and all policies, regarding your responsibilities. We encourage questions and/or concerns to avoid misunderstandings. PHI (Personal Protected Health Information) includes but is not limited to your medical records and personal information such as your demographics. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings, or concerns to the Compliance Officer. Our facility may use and disclose your PHI with or without your written authorization to anyone at any time for any reason including but not limited to health care delivery, your treatments, collecting money due this facility, to support any operation of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI. Privacy Rule allows you the right to review and receive copies of health care records as it relates to your health care. All request's must be in writing, allowing your provider 30 days to respond. Your provider may charge a copy fee or a processing fee for request of the medical records.

You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctors Authorization Notice. You have the right to file a written complaint with our compliance officer. You can obtain a complaint form from the compliance officer and /or the office of civil rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our facility from taking any retaliatory actions against anyone. I understand that the facility, its doctors, and staff are accepting my case based on examination findings and believe the outlined treatment should produce change and/or improvements. As with any diagnostic test, procedure, examination or doctor's care, a guarantee of improvement or complete recovery cannot be made, and it is even possible that no change will occur.

I further understand that in the practice of medicine, osteopathy, and chiropractic there are some risks

including fractures, disk injuries, strokes, heart-attacks, dislocations, sprains/strains, drug interactions, procedural complications, reactions, cardio-pulmonary arrest, death, and/or other incidents with may be short or long term or side effects which can not be predetermined. I do not expect the provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the provider to exercise judgement during the procedure which the provider feels at the time is in my best interest.

If you must miss an appointment, we ask that you notify us at least 24 hours in advance. We understand that the medical information about your and your health care is personal. This facility is required by law to abide by the terms of HIPPA. The Security Rule, as well as other applicable federal and state laws governing privacy practices in health care. By law, this facility is required for you, as a patient, to be aware and understand and agree to this.

In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or the planned course of treatment.

Patients have the right to refuse treatment but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with treatment your provider will discuss specific consequences with you. Therefore, I give my full consent to the provider to render treatment on me or the minor whom I am legally responsible for. I , the assignee, being the patient or legal guardian for said minor listed below, do hereby authorize, direct, and five a full lien to the office named above and listed, hereinafter referred to as the "facility" against any and all insurance benefits, proceeds of any settlement, judgement, or verdict which may be paid to the undersigned as a result of an accident, injury, illness, or health condition for which I have been treated by the facility. I further agree to pay all money and/or charges owed to this facility within 60 days of the date of occurrence, or treatment, even if an insurance claim submitted on my behalf is delayed or denied for any reason and/or a case manager or attorney representing me for any accident, injury, or illness has not settled my case. I, the assignee, further authorize and instruct any and all insurance companies, attorney and any and all third-party payers to pay directly to the facility in full all sums of money due them on any and all services rendered to me or any minor by who I am fully responsible for by reason of accident, workers compensation and/or including all insurance or third-party benefits. Also, my signature and as the assignee, I irrevocable agree that this facility may process medical reports, deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance by me, and authorize this facility to release any information pertinent to said health care to any insurance company, adjuster, attorney, or legal service bureau to facilitate collections under the terms if this document. Assignee grants the facility a full power of attorney to endorse and/or sign my name on all checks for payment to any indebtedness owed this facility an assignee.

As a courtesy, the facility will attempt to obtain a verification of your applicable insurance benefits and will report them to you or assume they are accurate, as they are quoted to us by some third-party payers, case managers, or attorneys misquote benefits, coverage, and liability. Any and all contractual, written, verbal or obligations are arrangements between you and an attorney, case manager, insurance company, liable or third-party payer are between you and said person or company and do not delay your obligation to pay.

Printed name of Patient: _____

Signature of Patient/Guardian of Minor: _____Date:_____

Dr. Larry Oteham, D.O.
111 W KY 80
Suite B
Somerset, KY 42503
Phone: 606.677.0101 Fax: 606.268.6454

Medical Lien

Patient Name: _____ Date of Loss: _____

Claim Number: _____ Attorney Name:
_____

I authorize and direct my attorney, to pay directly to Kentucky Accident & Injury Care, PLLC, any sums as may be due and owing for professional services rendered to me both by reason of this accident/injury and by reason of any other bills that are due to the provider and to withhold such sums from any settlement of judgement as is necessary to adequately protect the provider.
I hereby further give lien to the provider on any proceeds to which I may become entitled as a result of any settlement of judgement in any claim or litigation arising out of injuries for which I have been treated, of injuries connected therewith, whether such proceeds are remitted directly to me or to you, my attorney. I fully understand that I am directly responsible to the provider for all professional bills submitted by the provider for services rendered to me by the provider and that this agreement is made solely for the providers additional protection and in judgement or verdict by which I may eventually recover said fee. Attorney agrees to notify the Physicians immediately of the name/contacting information of any attorney substituted in his/her place.

Patient Signature: _____ Printed Name: _____

Date: _____ Parent/Guardian: _____

To the best of my knowledge and belief, statements and data contained herein are true, factual, accurate and complete, and any documents reproduced herein are true and accurate copies of the original.
Signed: _____
…….Subscribed, acknowledged and sworn to before me by _____ on this _____ day of _____, 20____. My Commission Expires _____.

_____
NOTARY PUBLIC

Please initial that you have received the signed Medical Lien from Kentucky Accident & Injury Care, PLLC.
Attorney Initials: _____ Date: _____
Note to Attorney: Please sign and return a copy to our office and retain a copy for your records.

Dr. Larry Oteham, D.O.
111 W KY 80
Suite B
Somerset, KY 42503
Phone: 606.677.0101 Fax: 606.268.6454

Medical Lien

Patient Name: _____ Date of Loss: _____

Claim Number: _____ Attorney Name:
_____

I authorize and direct my attorney, to pay directly to Kentucky Accident & Injury Care, PLLC, any sums as may be due and owing for professional services rendered to me both by reason of this accident/injury and by reason of any other bills that are due to the provider and to withhold such sums from any settlement of judgement as is necessary to adequately protect the provider.
I hereby further give lien to the provider on any proceeds to which I may become entitled as a result of any settlement of judgement in any claim or litigation arising out of injuries for which I have been treated, of injuries connected therewith, whether such proceeds are remitted directly to me or to you, my attorney. I fully understand that I am directly responsible to the provider for all professional bills submitted by the provider for services rendered to me by the provider and that this agreement is made solely for the providers additional protection and in judgement or verdict by which I may eventually recover said fee. Attorney agrees to notify the Physicians immediately of the name/contacting information of any attorney substituted in his/her place.

Patient Signature: _____ Printed Name: _____

Date: _____ Parent/Guardian: _____

To the best of my knowledge and belief, statements and data contained herein are true, factual, accurate and complete, and any documents reproduced herein are true and accurate copies of the original.
Signed: _____
…….Subscribed, acknowledged and sworn to before me by _____ on this _____ day of _____, 20____. My Commission Expires _____.

_____
NOTARY PUBLIC

Please initial that you have received the signed Medical Lien from Kentucky Accident & Injury Care, PLLC.
Attorney Initials: _____ Date: _____
Note to Attorney: Please sign and return a copy to our office and retain a copy for your records.

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Suite B
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Phone: 606.677.0101

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Suite 2101
Lexington, KY 40509
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Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me. By releasing a copy of my medical records, or a summary, or a narrative of my professional health information to Kentucky Accident & Injury Care, PLLC.

Patient Name: _____ Date of Birth: _____

____ Complete Medical Record	____ History & Physical	____ Progress Notes
____ Care Plan	____ Lab Reports	____ Radiology Reports
____ Pathology Reports	____ Treatment Records	____ Operative Reports
____ Hospital Reports	____ Medication Records	____ Other(please specify)

Please release my protected health information to the following physician/facility:

Name: Larry Oteham, D.O.
Facility: Kentucky Accident & Injury Care, PLLC
111 W KY 80
Suite B
Somerset, KY 42503

Signature: _____
Signature of Parent/Guardian:_____
Date: _____
Printed Name: _____
Printed Name of Parent/Guardian: _____
Date: _____

Patient Registration

Patient Name: _____ DOB: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Social Security Number: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

Guarantor-Responsible Party

Insured: _____ DOB: _____

Phone Number: _____ Social Security Number: _____

Address if different than patient's: _____

Insurance Information

Company: _____ Claim #: _____

Policy Number: _____ Phone Number: _____

Adjuster: _____ Adjuster Phone Number: _____

Adjuster Fax Number: _____

Would you like help finding an Attorney: _____Yes _____No

I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO KENTUCKY ACCIDENT AND INJURY CARE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I AUTHORIZE KENTUCKY ACCIDENT AND INJURY CARE OR MY INSURNACE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIM.

_____

_____

Signature of Patient/Legal Guardian and Relationship to Patient Date

_____

Printed Name of Patient/Legal Guardian

APPLICATION FOR BENEFITS - PERSONAL INJURY PROTECTION

KENTUCKY NO-FAULT

IMPORTANT:
1. TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE POLICYHOLDERS INSURANCE CONTRACT YOU MUST COMPLETE AND SIGN THIS FORM.
2. YOU MUST ALSO SIGN THE ATTACHED AUTHORIZATION(S).
3. **RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED, BUT DON'T WAIT FOR BILLS TO RETURN FORM**

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

APPLICATION FOR:

RETURN TO: _____

_____

_____

1. NAME | PHONE | HOME | BUSINESS

2. ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE) | DATE OF BIRTH | SOCIAL SECURITY NUMBER

3. DATE AND TIME OF ACCIDENT I AM PM | PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

4. BRIEF DESCRIPTION OF ACCIDENT

5. DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN A MOTOR VEHICLE? Yes NO YES
NAME OF INSURANCE COMPANY_____
_____
POLICY 0020575883

WERE YOU THE DRIVER OF THE MOTOR VEHICLE? YES NO
WERE YOU A PASSENGER IN THE MOTOR VEHICLE? YES NO
WERE YOU A PEDESTRIAN? YES NO
WERE YOU A MEMBER OF MOTOR VEHICLE OWNERS HOUSEHOLD? YES NO

HAVE YOU REJECTED THE LIMITATIONS ON YOUR RIGHT TO SUE AS PROVIDED BY KENTUCKY NO-FAULT ACT (KRS304.39) YES NO

6. AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? YES NO IF YOUR ANSWER IS **YES** COMPLETE THE REST OF THIS FORM, IF **NO** SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: _____ DATE: _____

7. DESCRIBE YOUR INJURY

8. WERE YOU TREATED BY A DOCTOR? YES NO | DOCTORS NAME AND ADDRESS : PHONE:

9. IF YOU WERE TREATED IN A HOSPITAL WERE YOU AN INPATIENT OUT-PATIENT | HOSPITAL NAME AND ADDRESS:

10. AMOUNT OF MEDICAL BILLS TO DATE: $_____ | WILL YOU HAVE MORE MEDICAL EXPENSE? YES NO | AT TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES NO

11. DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES NO | IF YES, AMOUNT LOST TO DATE $ | WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $

12. IF YOU LOST WAGES: DATE DISABILITY FROM WORK BEGAN: | DATE YOU RETURNED TO WORK:

13. HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENFITS UNDER: YES NO IF YES, HOW MUCH PER WEEK
(1) ANY WORKMENS COMPENSATION LAW? ____ ___ $ _____
(2) SOCIAL SECURITY BENEFITS (DISABILITY)? ____ ___ $_____

LIST NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER NAME:_____ PHONE NUMBER: _____
EMPLOYER ADDRESS: _____ CITY: _____ ZIP: _____
JOB DESSCRIPTION: _____ FROM: _____ TO: _____
CONTACT PERSON NAME: _____

PREVIOUS EMPLOYER: NAME: _____
ADDRESS: _____OCCUPATION: _____FROM:_____TO:_____

15. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES: YES NO IF YES, EXPLAIN ON REVERSE SIDE.

I hereby authorize release of medical information including, but not limited to, medical bills and reports to such persons as the company may deem necessary.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME

SIGNATURE: _____ DATE: _____

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS (KENTUCKY NO-FAULT) LAW.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

SIGNATURE :_____ DATE: _____

SOCIAL SECURITY NO._____ DATE OF BIRTH: _____

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS (KENTUCKY NO-FAULT) LAW.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

SIGNATURE: _____ DATE: _____

SOCIAL SECURITY NO._____ DATE OF BIRTH: _____