Sound Clinical Medicine, PS
Michael Wingren, MD
INDUSTRIAL INSURANCE FORM

TODAY'S DATE	PATIENT ID #

PATIENT INFORMATION: PLEASE PRINT AND ANSWER ALL QUESTIONS

FIRST NAME	INITIAL	LAST NAME			

ADDRESS	CITY	STATE	ZIP	HOME PHONE #

DATE OF BIRTH	SEX M☐ F☐	PATIENT'S SOCIAL SECURITY #	CELL PHONE #

EMPLOYER	BUSINESS PHONE#

CLAIM AND INJURY INFORMATION:

NEW CLAIM ☐ **CLAIM IS OPEN ☐** **CLAIM REOPENING ☐**

DATE OF INJURY	PLACE OF INJURY

EMPLOYER AT TIME OF INJURY	EMPLOYER PHONE#

IS EMPLOYER ? **STATE INDUSTRIAL INSURED ☐** **SELF INSURED ☐**

INDUSTRIAL INSURANCE INFORMATION:

INSURANCE COMPANY (L&I OR SELF INSURED COMPANY)	CLAIM #

SELF INSURED COMPANY ADDRESS	CITY	STATE	ZIP	INS CO. PHONE #

MEDICAL INSURANCE COVERAGE OTHER THAN INDUSTRIAL INSURANCE:

DO YOU HAVE OTHER MEDICAL INSURANCE COVERAGE ? **YES ☐** **NO ☐**

OTHER MEDICAL INSURANCE COMPANY	INSURED'S ID#	INSURED'S NAME

MEDICAL INFORMATION:

ALLERGIES TO DRUGS	PHARMACY NAME	PHARMACY PHONE #

SPOUSE'S NAME	CHILDREN (NAMES / AGES)	SPOUSE'S EMPLOYER	BUSINESS PHONE #

REFERRED BY	NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY (OTHER THAN ABOVE)	PHONE#

HIPAA: ACKNOWLEDGEMENT OF RECEIPT/OFFER OF NOTICE OF PRIVACY PRACTICES

Federal law requires us to provide you with a Notice of Privacy Practices, which is our explanation of how we use and disclose your health information, and to ask you to acknowledge that you have received the notice. You have the right to review our notice before signing this acknowledgment, and, if you have any questions, to ask for an explanation of any part of the Notice, or any other aspects of our use and disclosure of your health information. If we change our Notice, we will make revised copies available to you when you visit us, and will send you a revised copy upon your request. We appreciate you signing this form, which acknowledges that you have received, or have been offered and refused, a copy of our Notice.

Signed: Date:

ASSIGNMENT AND RELEASE:

If, for some reason, Industrial Insurance rejects the claim or refuses to pay the medical bills, I give Dr. Wingren and Sound Clinical Medicine, PS, permission to bill my private medical insurance for those services rendered.
I hereby Authorize my Insurance Benefits be paid directly to Sound Clinical Medicine, PS, and I am personally financially responsible for any balance due I also authorize Dr. Wingren and Sound Clinical Medicine, PS to release any information needed to process my insurance claims.
I also understand that a periodic monthly finance charge of 1% monthly (or a $10.00 minimum monthly charge) may be applied to any unpaid balance over 30 days past due.

Signed: Date: