**Benrus Surgical**
at Barnes Jewish St. Peters

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## INFORMATION FOR WORKERS COMPENSATION PATIENT

NAME: _____ DATE: _____

ADDRESS: _____ PHONE: _____

_____ CLAIM #: _____

DATE OF BIRTH: _____ AGE: _____

WORK COMP CONTACT NAME: _____ PHONE: _____

EMPLOYER: _____ PHONE: _____

EMPLOYER ADDRESS: _____

DATE OF INJURY: _____ DATE YOU LAST WORKED: _____

PART OF BODY INJURED: _____

X-RAYS TAKEN: _____ WHERE: _____

BRIEF DESCRIPTION OF HOW INJURY OCCURRED: _____

_____

_____

PROBLEMS RESULTING FROM INJURY: _____

_____

MISSED WORK DATES (IF ANY): _____

DATE INJURY REPORTED TO EMPLOYER: _____

DRUG ALLERGIES: _____

CURRENT MEDICATIONS: _____

NAME OF ATTORNEY: _____ PHONE: _____

I UNDERSTAND IF THIS CLAIM IS DENIED BY WORKERS COMPENSATION INSURANCE, I WILL BE PERSONALLY RESPONSIBLE FOR ANY CHARGES INCURRED IN RELATION TO THE TREATMENT OF THIS INJURY AND AGREE TO PAY ANY SUCH CHARGES.

SIGNATURE: _____ DATE: _____

BJC Medical Group

Name: _____

DOB: _____

## Receipt of Notice of Privacy Practices

Initial _____ I acknowledge I have received or I have been provided the opportunity to receive a copy of BJC's Notice of Privacy Practices that explains when, where and why my protected health information may be used or shared by BJC Medical Group.

## Patient Communication Preferences

**Phone number** for voice message(s): _____

**Cell number** for text message(s): _____

**Email address:** _____

## HIPAA Disclosure Authorizations(s)

Initial _____ **I authorize BJC Medical Group to provide the following person(s) with my protected health information:**

Print Name: _____ Relationship to Patient/Phone number: _____

Print Name: _____ Relationship to Patient/Phone number: _____

OR

Initial _____ **I do not authorize BJC Medical Group to:**

Disclose my protected health information to anyone other than myself, except as permitted by HIPAA and as described in BJC's Notice of Privacy Practices.

## Prescription Authorization

Initial _____ I authorize BJC Medical Group to allow the following person(s) to pick up prescriptions on my behalf:

Print Name: _____ Relationship to Patient: _____

Print Name: _____ Relationship to Patient: _____

I understand the HIPAA Disclosure Authorization(s) above may be revoked in writing at any time; however, the revocation will not affect disclosures of information previously authorized. I understand this authorization is valid while I continue to receive services from any BJC Medical Group provider.

_____ _____ _____

Signature of Patient/Personal Representative | Relationship to Patient | Date