Lowney Medical Associates

1234 Hyde Park Avenue, Suite 101, Hyde Park, MA. 02136 T: 617-364-2420 F: 617-364-1845

Name_____ **Date of Birth** _____ Today's Date _____

Work Related Injury? Y or N **Date of Injury**_____ Job Description_____

Auto Injury? Y or N **Date of Injury**_____ Year and type of Auto_____

Other type of Injury? _____ **Date of Injury:**_____

Supervisor name: _____ Phone _____

Were you seen in an Emergency Room? Y or N Date of E.R. visit _____

Please describe **in detail** how the injury occurred:_____

_____

_____

_____

Please describe **all areas** of your body that have been injured:_____

_____

_____

In the past have you ever been examined by a medical provider for similar injuries? Y or N
If you have had similar injuries in the past please provide the areas of your body and date of previous injuries: _____

_____

_____

Were you employed prior to the injury? Y or N Name of Employer if yes _____

Have you missed and days of work since the injury? Y or N Number of days missed: _____
Have you decreased your work hours or *lightened* your duties since the injury? Y or N

Please briefly describe the **regular** daily activities of your job (heavy lifting, etc.)

_____

_____

_____

PATIENT INFORMATION

Please list auto information for vehicle in which you were first injured:

Name of Auto Insurance: _____

Address: _____

Phone#: _____ Claim#: _____

Ins. Adjuster: _____ Ext#: _____

Other vehicle information if available:

Name of other vehicle's insurance: _____

Address: _____

Phone#: _____ Claim#: _____

Ins. Adjuster: _____ Ext#: _____

Attorney Information:

Name: _____ Phone# _____

Worker's compensation info *if **work** related injury*:

Name of Worker's comp Insurance: _____

Address: _____

Phone#: _____ Claim#: _____

Ins. Adjuster: _____ Ext#: _____

I verify that all the information provided is true and correct. I agree to promptly notify Lowney Medical of any change in this information until my account is paid in full. I understand that my insurance will be billed as a courtesy, and that I remain fully responsible for all charges that I incur.

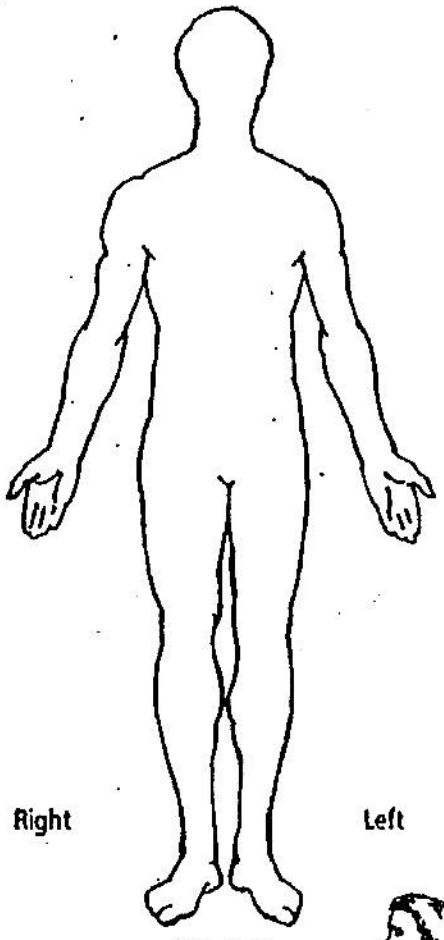
Signature of patient: _____ Date: _____

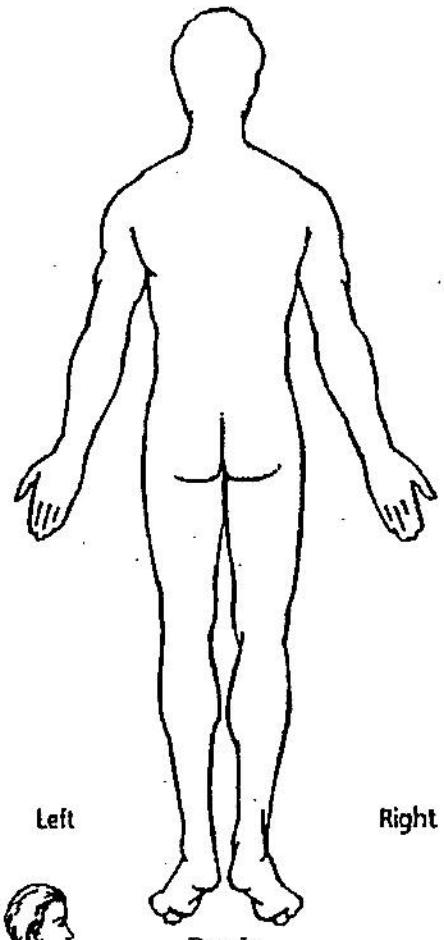
Patient Pain Drawing

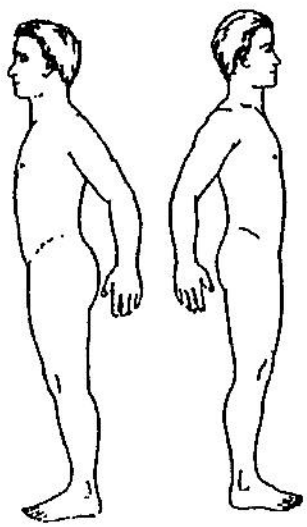
Name _____ Date _____

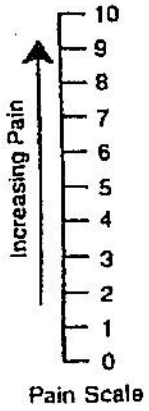
Where is your pain now?
Mark the areas on your body where you feel the sensations desribed below, using the appropriate symbol.
Mark the areas of radiation. Include all affected areas.
To complete the picture, please draw in your face.

Aching	Numbness	Pins and needles	Burning	Stabbing
▲ ▲ ▲	= = = =	○ ○ ○ ○	X X X	/ / / / /









Lowney Medical Associates, Inc.

Charles W. Lowney, DO
F.A.C.F.P., F.A.B.C.N.

Diplomat of the American Board of Orthopedic & Neurological Medicine

Board Certified in Disabiltiy Education

Certified in Pain Management, Family Practice Medicine and Tramatic Stress

Jeremiah J. Lowney, DO
F.A.C.P.

Diplomat American Board of Internal Medicine

Diplomat American Board of Osteopathic Medicine

Member of the American College of Physicians

Member of Mass Medical Society

Michael P. Lowney, DO

Primary Care Medicine
Osteopathic Medicine
Musculoskeletal Medicine

Member of the American Osteopathic Association

IRREVOCABLE ASSIGNMENT, LIEN AND AUTHORIZATION OF INSURANCE BENEFITS AND ATTORNEY

Affilated with

-New England Baptist Hospital
-Beth Israel Deaconess-Medical Center
-Milton Hospital

To Whom It May Concern:

I hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to _Lowney Medical Associates, Inc_, such sums as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office. Withhold such sums from any disability benefits, medical payment benefits, no fault benefits, health and accident benefits, worker's compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately pay said Office. I hereby further give a lien to said Office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me ass a result of the injuries or illness for which I have been treated for by said Office. This is to act as an assignment of my rights and benefits to the extent of the Office's services provided.

In the event my insurance company obligated to make payments to me upon the charges made by this Office for their services refused to make such payments upon demand by me or this Office, I hereby assign and transfer to this Office any and all caused of action that I might have or that might exist in my favor against such company and authorize this Office to prosecute said cause of action either in my name or in the Office's name and further I authorize this office to compromise, settle or otherwise receive such claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due the Office for these services. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize the Office to release any information pertinent to my case to any insurance company, adjustor or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Office be given power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

I further understand and agree that if this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this Office for all costs of such collection efforts, including but not limited to all court costs and all attorney fees.

Signed _____ **Date**_____

Print_____

1234 Hyde Park Ave.
Hyde Park, MA 02136
www.towneymed.com

(617) 364-2420
fax (617)364-1845