



**MEDICAL INTAKE FORM**

Date: \_\_\_\_\_ Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Please Circle: Male or Female

Marital Status (please circle): S M D W Social Security Number: \_\_\_\_\_ E-Mail \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Please list condition(s) in order of concern:**

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

Is this condition(s) related to an auto accident or work injury? YES \_\_\_\_\_ NO \_\_\_\_\_

Describe: \_\_\_\_\_

When did this condition begin/when did you first notice it: \_\_\_\_\_

Describe: \_\_\_\_\_

What activities aggravate your symptoms? \_\_\_\_\_

Is there anything that has relieved your symptoms? YES \_\_\_\_\_ NO \_\_\_\_\_

Describe: \_\_\_\_\_

Have you experienced this condition before? YES \_\_\_\_\_ NO \_\_\_\_\_ Who have you seen for this? \_\_\_\_\_

What did they do? \_\_\_\_\_ How did you respond? \_\_\_\_\_

How committed are you to getting rid of your problem? Very Committed \_\_\_\_\_ Not very Committed \_\_\_\_\_

**Medical History: Please check all that apply**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Depression                  | <input type="checkbox"/> Kidney or Bladder Disease    |
| <input type="checkbox"/> Allergies (Hay fever)    | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Liver or Gallbladder Disease |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Diverticular Disease        | <input type="checkbox"/> Migraine Headaches           |
| <input type="checkbox"/> Alcoholism               | <input type="checkbox"/> Emphysema                   | <input type="checkbox"/> Neurological Problems        |
| <input type="checkbox"/> Blood Pressure           | <input type="checkbox"/> Eyes, Ears, Nose Throat     | <input type="checkbox"/> Sinus Problems               |
| <input type="checkbox"/> Bronchitis               | <input type="checkbox"/> Environmental Sensitivities | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Fibromyalgia                | <input type="checkbox"/> Obesity                      |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Gastroesophageal Reflux     | <input type="checkbox"/> Osteoporosis                 |
| <input type="checkbox"/> Carpal Tunnel Syndrome   | <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Cholesterol-Elevated     | <input type="checkbox"/> Gout Heart Disease          | <input type="checkbox"/> Seasonal Affective Disorder  |
| <input type="checkbox"/> Circulatory Problems     | <input type="checkbox"/> Infection, Chronic          | <input type="checkbox"/> Skin Problems                |
| <input type="checkbox"/> Colitis                  | <input type="checkbox"/> Inflammatory Bowel Disease  | <input type="checkbox"/> Ulcer                        |
| <input type="checkbox"/> Dental Problems          | <input type="checkbox"/> Irritable Bowel Syndrome    | <input type="checkbox"/> Urinary Tract Infections     |



Varicose Veins

Thyroid

Other \_\_\_\_\_

**Operations:**

Appendectomy

Cholecystectomy

Hysterectomy

Prostate

Tonsillectomy

\_\_\_\_\_

**Allergies (please list):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any prescription medications, OTCs (over the counter medications), vitamins, minerals, supplements you are taking. Please list the amounts (i.e. 500 mg tablet 2x/day), when you take them (schedule) and why you are taking them. If you need more room, use bottom and/or back of page.

**Prescription Medications**

**Over-The-Counter Medications**

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**Vitamins/Minerals**

**Other Supplements**

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**PLEASE ONLY FILL OUT THIS PAGE OUT IF YOU WERE INJURED IN AN  
AUTOMOBILE WORK ACCIDENT**

1. Were you the  driver  the passenger  a pedestrian  on a bicycle  on a motorcycle.
2. Were you  hit (by another vehicle) or  at fault (you caused the accident)?
3. From which side were you struck  behind  the front  the right side  the left side  the right front  the left front  the right back  
 the left back.
4. At the time of impacted were you  stopped  moving  walking  standing still  running  bicycling  riding a motorcycle  crossing the street.
5. Were you moving at the time of the accident  yes or  no? **If yes**, what was your speed \_\_\_\_\_?
6. Was the involved party moving when the accident occurred  yes or  no, **If yes** what was there speed \_\_\_\_\_?
7. Did you have your seatbelt on at the time of the accident  yes  no?
8. Was your head turned at the time of the accident  yes or  no, **If yes** were you looking  forward  looking to the right  looking to left  
 looking behind you  looking up  looking down.
9. Were you alone at the time of the accident  yes or  no?
10. What parts of your body hit other structures at the time of impact  head  face  forehead  back of head  
 right shoulder  left shoulder  right arm  left arm  right elbow  
 left elbow  right wrist  left wrist  right hand  left hand  
 Right leg  left leg  right knee  left knee  right ankle  left ankle  
 right foot  left foot
11. What structures did you hit?  steering wheel  windshield  side window  door  roof  dashboard  headrest  seat  floor  Side of car   
hood of car  bumper  trunk  
 the pavement  tree  another car  another person  another object  
 a wall
12. How did you feel after the collision?  stunned  disoriented  lost consciousness  tightness  felt mild discomfort  felt moderate discomfort  
 felt severe discomfort  felt intense pain  frightened  felt a popping and ripping sensation  when to hospital
13. Who was cited for the accident  me  other driver

**Physical History: Please check all that apply.****Head:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Headaches-one sided  | <input type="checkbox"/> Headaches-involves back of neck             | <input type="checkbox"/> Headaches-interfere with work |
| <input type="checkbox"/> Confusion, Brain Fog | <input type="checkbox"/> Dizziness, Unsteadiness                     | <input type="checkbox"/> Change in memory              |
| <input type="checkbox"/> Blurred Vision       | <input type="checkbox"/> Headaches-associated with light sensitivity |  |
| <input type="checkbox"/> Other _____          |  |  |

**Eyes**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Itching            | <input type="checkbox"/> Dryness           | <input type="checkbox"/> Puffy under eyes |
| <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> Cataracts         | <input type="checkbox"/> Dark circles     |
| <input type="checkbox"/> Sensitive to light | <input type="checkbox"/> Corrective Lenses | <input type="checkbox"/> Other _____      |

**Ears:**

- |                                       |  |                               |
|---------------------------------------|--|-------------------------------|
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Ringing/Roaring | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Drainage     | <input type="checkbox"/> Other _____     |                               |

**Nose:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Itches                | <input type="checkbox"/> Sneeze                    | <input type="checkbox"/> No sense of smell |
| <input type="checkbox"/> Runs                  | <input type="checkbox"/> Requires nose drops/spray | <input type="checkbox"/> Sinus infection   |
| <input type="checkbox"/> Blood streaked mucous | <input type="checkbox"/> Other _____               |  |

**Mouth and Throat**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Snore             | <input type="checkbox"/> Bad breath            | <input type="checkbox"/> Sore throats         |
| <input type="checkbox"/> Wears dentures    | <input type="checkbox"/> Hoarseness            | <input type="checkbox"/> Grind teeth in sleep |
| <input type="checkbox"/> Neck glands swell | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Other _____          |

**Cardiac and Respiratory**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Wheeze               | <input type="checkbox"/> Bronchitis      | <input type="checkbox"/> Murmur           |
| <input type="checkbox"/> Rapid heart beats    | <input type="checkbox"/> Chest pains     | <input type="checkbox"/> Productive cough |
| <input type="checkbox"/> Non-productive cough | <input type="checkbox"/> Skipped beats   | <input type="checkbox"/> Cough up blood   |
| <input type="checkbox"/> Ankle swelling       | <input type="checkbox"/> Short of breath | <input type="checkbox"/> Night sweat      |

**Gastrointestinal/Digestion**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Heartburn           | <input type="checkbox"/> Indigestion     | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Cramping            | <input type="checkbox"/> Mucous in stool | <input type="checkbox"/> Bloating        |
| <input type="checkbox"/> Stomach aches       | <input type="checkbox"/> Anal pain       | <input type="checkbox"/> Excess gas      |
| <input type="checkbox"/> Rectal bleeding     | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Constipated     |
| <input type="checkbox"/> Belching frequently | <input type="checkbox"/> Blood in stool  | <input type="checkbox"/> Other _____     |

**Urinary and Genitalia:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Frequent urination   | <input type="checkbox"/> Painful urination             | <input type="checkbox"/> Pass blood                     |
| <input type="checkbox"/> Kidney stones  | <input type="checkbox"/> Weak stream                   | <input type="checkbox"/> Genital herpes                 |
| <input type="checkbox"/> Yeast infection  | <input type="checkbox"/> Difficulty starting urination | <input type="checkbox"/> Lumps, pain swelling testicles |
| <input type="checkbox"/> Unsatisfactory sexual relations                            | <input type="checkbox"/> Burning                       |   |
| <input type="checkbox"/> Present or previous cancer of the kidneys or urinary tract |  |   |

**Endocrine**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Fatigue  | <input type="checkbox"/> Sleepiness in the afternoon  | <input type="checkbox"/> Crave salt                         |
| <input type="checkbox"/> Heat intolerance   | <input type="checkbox"/> Light headed upon standing   | <input type="checkbox"/> Catch colds or infections easily   |
| <input type="checkbox"/> Crave sugar  | <input type="checkbox"/> Difficult getting out of bed | <input type="checkbox"/> Loss of libido                     |
| <input type="checkbox"/> Reaction time slowed down                                      | <input type="checkbox"/> Deepening of voice           | <input type="checkbox"/> Weight gain for no apparent reason |
| <input type="checkbox"/> Feel puffy or swollen all over your body                       | <input type="checkbox"/> Cold intolerance             |   |
| <input type="checkbox"/> Feel cold, chilled-hands, feet all over for no apparent reason |   |   |

**Musculoskeletal**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Muscle weakness   | <input type="checkbox"/> Other _____                        | <input type="checkbox"/> Decreased strength |
| <input type="checkbox"/> Morning stiffness                                       | <input type="checkbox"/> Muscle cramps                      | <input type="checkbox"/> Muscle twitching   |
| <input type="checkbox"/> Back pain   | <input type="checkbox"/> Joint swelling, pain or stiffness  |   |
| <input type="checkbox"/> Numbness/tingling of hands and feet                     | <input type="checkbox"/> Increased redness, warmth of joint |   |
| <input type="checkbox"/> Parts of the body feel tender, sore, sensitive to touch |   |   |



**Skin:**

- Eczema
- Easy bruising
- Brittle nails
- Hives
- Dry skin
- Other\_\_\_\_\_
- Rash
- Oily

**Psychological:**

- Often unhappy
- Difficulty falling asleep
- Misunderstood by others
- Unable to concentrate
- Use tranquilizers
- Considered a nervous person
- Easily flare in anger
- Frequently keyed up and jittery
- Am a workaholic
- Extremely shy or sensitive
- Difficulty staying awake
- Other\_\_\_\_\_

**Social History: Please circle all that apply.**

Married: Yes No If yes, how long\_\_\_\_\_

Children: Yes No If yes, how many\_\_\_\_\_

Occupation\_\_\_\_\_

Cigarettes: Yes No If yes, how much/day\_\_\_\_\_How many years\_\_\_\_\_

Cigars: Yes No If yes, how many/day\_\_\_\_\_or week\_\_\_\_\_

Chewing Tobacco: Yes No

Alcohol: Yes No If yes, drinks/day or week\_\_\_\_\_

Coffee: Yes No If yes, cups/day\_\_\_\_\_

**PMI/FH:**

Have you or any of your family members had any of the problems listed in this chart? Please indicate by checking the appropriate box.

	Father	Mother	Grandparents	Siblings	Children
Alcoholism					
Anemia					
Arthritis					
Asthma					
Cancer					
Diabetes					
Emphysema					
Heart Disease					
High Blood Pressure					
Osteoporosis					
Mental Illness					
Thyroid Disorders					
Others-List					

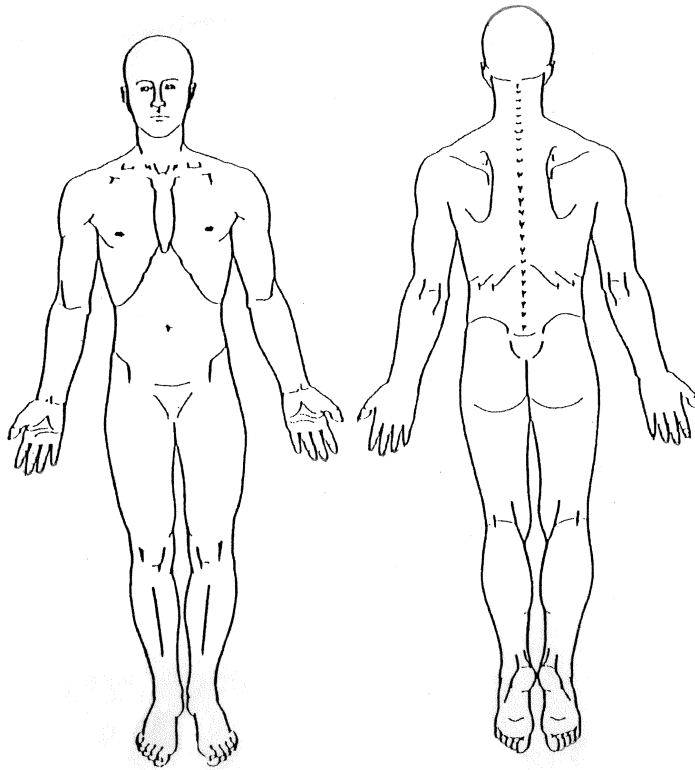


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Please check the boxes below that reflect any symptoms that you may be experiencing or experienced in the past 6 months:

	Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling
Head							
Neck							
Upper Back							
Mid Back							
Lower Back							
Shoulder							
Arm							
Forearm							
Wrist							
Hand							
Ribs							
Buttock							
Hip Thigh							
Leg							
Knee							
Ankle							
Foot							

Please circle/mark your area(s) of the signs and symptoms listed above.





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## INSURANCE COMPLIANCE INFORMATION

We would like to take a moment to welcome you to our office and assure you that your treatment is our top priority. We find that many patients are very confused when using their insurance and are concerned about their financial obligations. This form is utilized to explain your responsibilities when our office files your insurance.

At Dynamic our staff provides you with all insurance filing at the time of service. We will verify all insurance benefits to assure your chiropractic/medical coverage's in full. However, we need to make you aware that these benefits are not a guarantee of payment and you will ultimately be responsible for all services that are not paid by your insurance company. It is very important that you understand that our office, as a service to our patients, will submit and make all attempts to collect all outstanding payments. We will not enter into any disputes with your insurance company. If your account remains in an outstanding status, our staff may request your help in expediting payment from your insurance company.

Each patient is required to meet their deductible in full before their insurance company will pay their portion. At this time, our staff will notify you of your out of pocket expense at your time of service. Most insurance company policies require a payment of 30%-50% of the patients visit. Our staff is required to collect this amount at the time of service. If your insurance policy requires a co-pay, this amount will be requested at the time of service. It has become a standard that doctors' request all payment in full at the time of service. Our office continues to service our patients the old fashion way and will do the work for you. This allows you to focus on your health.

### Personal Injury Patient With Health Insurance:

If you were involved in an automobile accident and have a health care policy, our office will submit all charges at the time of service. You will not be responsible to pay for any deductible or co-pay at the time of service. Any outstanding balance will be reimbursed by your attorney when your case is settled.

### What To Do When My Insurance Company Sends Me A Check:

Many insurance companies will send the member (patient) a check to your home instead of our office by accident. If this situation occurs, please be advised that you are to bring the check and accompanying explanation of benefits to the office so that it can be posted to your account.

### What Do I Do If My Insurance Company Sends Me Forms That I Do Not Know How To Answer?

Many times an insurance company will send a patient a questionnaire for them to fill out. These forms purposely are used as stall tactics and are quite confusing for you to understand. When you receive these letters, please either call our office or bring them to our office manager for proper clarification.

### Financial Consent/Patient Agreement:

I understand and agree to the services that my doctor has offered to me. I agree to be fully responsible for any services that are not paid by my insurance company and understand that my doctor will send all outstanding accounts to a collection agency after 60 days if not reconciled by the responsible party.

I am not an agent or representative of any insurance company or any other business trying to collect information. All injuries/problems mentioned are true and I am here solely for the treatment of the said problems.

**Patient Initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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**IRREVOCABLE ASSIGNMENT, LIEN AND AUTHORIZATION**  
**INSURANCE BENEFITS**

TO WHOM IT MAY CONCERN:

I hereby authorize and direct you, my insurance carrier to pay directly to **Dynamic** 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 and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident, Workers' 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 protect **Dynamic** I hereby further give 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 as a result of the injuries or illness for which I have been treated for by **Dynamic**. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due the office for services rendered. 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 carrier or adjuster to facilitate collection under this Assignment, Lien and Authorization.

I further understand and agree that if **Dynamic** must take any action to collect an outstanding balance on this 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.

\_\_\_\_\_(SEAL)  
**Patient Signature**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Insurance Company Name and Address

**PATIENT ACKNOWLEDGEMENT OF**  
**RECEIPT OF NOTICE**

I hereby acknowledge receipt of the Notice of Privacy Practices for **Dynamic** regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized and disclosed by Clinic and my respective rights contained there in. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting **Dynamic 3707 Chamberlain Ln Louisville, KY 40241 (502) 426-9200**

My signature herein below constitutes full acknowledgement that I have furnished a copy of the Notice of Privacy Practices for **Dynamic**

PRINT Patient's Name: \_\_\_\_\_

**SIGNATURE of Patient:** \_\_\_\_\_ Date: \_\_\_\_\_

SIGNATURE of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



DYNAMIC

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**CONSENT TO TREAT**

I hereby authorize the Doctor's to treat my case as they deem appropriate through the use of physical therapy, rehabilitation, manual therapy, chiropractic manipulation of the spine, nutritional support, trigger point injection and diagnostic testing. I realize the goal of holistic healthcare is to strengthen the patient's body in order to heal themselves.

It is understood and agreed the amount paid the clinic for x-rays is for interpretation and only the x-ray negatives will remain the property of this office, being on file. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Initials \_\_\_\_\_

Date: \_\_\_\_\_

**X-RAY QUESTIONNAIRE: FOR WOMEN ONLY**

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: \_\_\_\_\_

- There is a possibility that I may be pregnant at this time.
- Yes. I am definitely pregnant
- No. I am definitely not pregnant at this time
- I request that x-ray films not be taken because \_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_

\_\_\_\_\_  
Patient Initials

\_\_\_\_\_  
Date



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## HIPPA / HEALTH CARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES **DYNAMIC** TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Dynamic to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

I give permission to Dynamic to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a Doctor in private, the Doctor will provide a private room for these conversations. By signing the following you are giving Dynamic Chiropractic and Rehab permission to use and disclose your protected health information in accordance with the directives listed above

### ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I \_\_\_\_\_ on this date \_\_\_\_\_ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges:

- \* The right to review the notice prior to signing this consent
- \* The right to object to the use of my health care information for directory purpose
- \* The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations

### PLEASE READ THE FOLLOWING

At this time, we ask that you hand your application to the front desk. They will now assist you on how you will describe your **complaints and/or symptoms** on the Kiosks in the lobby. Please be sure to mark all areas of discomfort, one area at a time. Thank you.

**NOTE: Your health information will be kept strictly confidential.** Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.



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COMMONWEALTH OF KENTUCKY  
DEPARTMENT OF WORKERS' CLAIMS  
Claim No. \_\_\_\_\_  
NOTICE OF DESIGNATED PHYSICIAN

EMPLOYEE: \_\_\_\_\_

Name

Street Address

City, State, Zip Telephone Number

Date of Birth Social Security Number

EMPLOYER AT TIME OF INJURY OR LAST EXPOSURE:

Name

Street Address

City, State, Zip

NATURE OF INJURY OR OCCUPATIONAL DISEASE: \_\_\_\_\_

DATE OF INJURY OR LAST EXPOSURE: \_\_\_\_\_

FIRST DESIGNATED PHYSICIAN:

Name

Street Address

City, State, Zip Telephone Number

Accepted by: \_\_\_\_\_

MEDICAL INFORMATON RELEASE: I hereby waive any privilege I may have to restrict the release of information or written material reasonably related to the work-related injury/disease for which I have sought treatment, and I consent to the release of this information or written material to the medical payment obligor, my employer, Special Fund, Uninsured Employers' Fund, or attorneys representing me or any of the parties named above.

Date Employee Signature

MEDICAL PAYMENT OBLIGOR:

Name of Obligor

Representative

Street Address

City, State, Zip Telephone Number

This form identifies the designated physician and must be returned to the medical payment obligor within ten (10) days after treatment begins. An Identification card will be provided to the employee, and that card should be presented when medical treatment is required.



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Notice: The Workers' Compensation Act requires the employer to pay for the medical services

Reasonably necessary for cure and relief from the effects of a workplace injury or disease.

The employee may choose the physician (including chiropractors, etc.) who treats him as

"designated physician." The designated physician is responsible for the coordination of the employee's medical care and may refer the patient to consulting or treating physicians as required.

Except in an emergency, all treatment must be performed by or on referral from the designated physician. The employee may not change his designated physician more than once without the medical payment obligor's consent.

Inquires shall be made to the listed representative of the medical payment obligor.

This form is not advance authorization from the workers' compensation medical payment obligor for

Medical services.