Old Pueblo Medical Financing

NEW CLIENT INTAKE

ATTORNEY INFORMATION

Law Firm: _____ **Attorney Name:** _____ ☐ Mr. ☐ Ms.

Law Firm Contact Name *(if not attorney)*: _____ ☐ Paralegal ☐ Case Manager ☐ Asst. ☐ Other

State: ____ **Email:** _____ **Phone:** (___) ___ - ____ ☐ Office ☐ Cell

CLIENT INFORMATION

Full Name: _____ ☐ Mr. ☐ Ms. **Language:** ☐ English ☐ Spanish ☐ Other _____

Phone: (___) ___ - ____ **Email:** _____ _____ **DOB:** ___ - ___ - ____ **SSN:** ___ - ___ - ____

Address: _____ **City:** _____ **State:** ___ **Zip Code:** _____

Client Type: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Cyclist ☐ Other _____ **Was client employed at time of injury?** ☐ Yes ☐ No

CASE INFORMATION

Incident Date: ___ - ___ - ____ **Police Department:** _____ _____ **Police / Incident Report:** ☐ Attached ☐ N/A

Police Report Number: _____ **Number of Claimants:** _____ **Is this Workers' Compensation?** ☐ Yes ☐ No

Accident: ☐ Rear-End ☐ Sideswipe ☐ Side-Impact ☐ Head-on ☐ T-Bone ☐ Rollover ☐ Slip & Fall/Bodily Injury ☐ Other _____

Road Type: ☐ Highway ☐ Intersection ☐ Parking Lot ☐ Street ☐ Other **Property Damage?** ☐ Total Loss ☐ Repairable $_____

Brief Description: _____

Has client been involved in a prior accident(s)? ☐ Yes ☐ No **If yes, list incident date(s) and type(s) of injuries sustained in each:**

_____

Does client have any pre-existing health conditions? ☐ Yes ☐ No **If yes, state the nature of client's pre-existing conditions:**

_____

Client Vehicle: Year _____ Make _____ Model _____ **Adverse Vehicle:** Year _____ Make _____ Model _____

ADVERSE/DEFENDANT INSURANCE INFORMATION

Liability Accepted? ☐ Yes ☐ No ☐ Investigating **Policy Limits $**_____ ____ **Policy/Claim #:** _____

Insured Full Name: _____ _ **Insurance Company:** _____ **Phone:** (___) ___ - ____

CLIENT/PLAINTIFF INSURANCE INFORMATION

Type(s) of Coverage/Limits: ☐ UM ☐ UIM ☐ Med-Pay ☐ PIP **Limits Available: $**_____ **Policy/Claim #:** _____

Insurance Company: _____ **Phone:** (___) ___ - ____ **Is client Medicare or Medicaid insured?** ☐ Yes ☐ No

Did client carry private health insurance at the time of incident? ☐ Yes ☐ No **Is client Medicare or Medicaid eligible?** ☐ Yes ☐ No

When do you anticipate this claim to settle? ☐ 0-2 Months ☐ 3-6 Months ☐ 7-9 Months ☐ 10-12 Months ☐ 1-2 Years ☐ 2+ Years

TREATMENT INFORMATION

Medical Bills to date (*estimate*): $_____ **Type of Treatment to date:** _____

Ambulance? ☐ Yes ☐ No **Description of Injuries:** _____

Hospital? ☐ Yes ☐ No **If yes, Hospital Name:** _____ **City:** _____ _____ **State:** ____

Date of First Treatment? ___ - ___ - ____ **Treatment requested:** ☐ Physical Therapy ☐ MRI/Imaging ☐ Ortho-Extremity ☐ Ortho-Spine

☐ Pain Management ☐ Neurology ☐ Psychological Evaluation ☐ Initial Medical Evaluation ☐ Other _____ _____

OTHER INFORMATION

Is there any additional information you would like to include that may be helpful?

_____