# CHRISTOPHER CHEN, M.D., INC.

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## AME Intake

Type of Appointment: ☐ AME ☐ AME RE-EVALUATION

**PLEASE FILL OUT ENTIRE FORM AND TYPE OR PRINT LEGIBLE**

**(if a field does not apply to you please indicate with n/a; so that the intake is still complete)**

CLAIM No.: _____ Date of Request _____

Name of Person Completing Intake: _____ Phone No.: _____

Requesting Apt. on Behalf of (Check One):
- ☐ Applicant's Atty.
- ☐ Defense Atty.
- ☐ Employee
- ☐ Adjuster

Location of Apt.:
- ____ OAKLAND
- ☐ PLEASANTON
- ☐ SACRAMENTO
- ☐ SAN MATEO
- ☐ RICHMOND
- ☐ FREMONT
- ☐ MODESTO
- ☐ SAN JOSE
- ☐ WALNUT CREEK
- ☐ SAN FRANCISCO

Certified Interpreter Required: ☐ Yes ☐ No (If Yes, what language): _____

Name of Certified Interpreting Service: _____ Phone No.: _____

Which Party Will Arrange for Interpreter (Check One): ☐ Applicant's Atty. ☐ Defense Atty. ☐ Adjuster

## PATIENT

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Sex: ☐ M ☐ F

SSN: _____

Home No.: _____ Cell No.: _____

Street Address _____

City: _____ State: _____ Zip Code: _____

E-Mail

## INJURY

Date of Injury:

Occupation at time of Injury:

Body Part(s) Injured:

Employer at time of Injury

Phone:

Street Address:

City

State:

Zip Code:

## INSURANCE CARRIER

Adjuster Name:

Insurance Carrier:

Street Address:

City:

State

Zip Code:

Phone No.:

Fax No.:

E-Mail

## APPLICANT'S ATTORNEY

Attorney Name:

Firm Name:

Street Address:

City:

State:

Zip Code:

Phone No.:

Fax No.:

E-Mail

## DEFENSE ATTORNEY

Attorney Name:

Firm Name:

Street Address:

City: State: Zip Code:

Phone No.: Fax No.:

E-Mail:

**I've read the disclaimer below. (noted on page 3)** * Name of person submitting this AME Intake:

Optional Comments:

**DISCLAIMER:**

**- NOTIFICATION OF APPOINTMENT :**

Notification of appointment and a copy of these disclaimers/ AME policies are provided to the parties listed on the proof of service. We receive the information (names, addresses, fax numbers, etc.) from the rescheduling party and use that information to complete the proof of service. If they are inaccuracies in the proof of service or any documentation for the AME evaluation, please notify the office immediately.

**- FAILURE TO APPEAR :**

Appointment must be cancelled no later than two weeks prior to scheduled appointment. Failure to appear (patient or interpreter) will result in a no show fee of $500.00. The party scheduling appointment is informed written and verbally of our cancellation policy at the time of the appointment is scheduled.

**- CANCELLATIONS :**

ONLY the scheduling party may cancel an AME appointment. Written documentation must be provided to cancel an appointment; verbal request are not accepted nor confirmation an appointment has been cancelled.

**- MEDICAL RECORDS**

To provide you with timely reports, we require records to be sent a minimum of 2 weeks prior to the scheduled appointment. If records are not received at least 72 hours prior to the scheduled appointment, the appointment may be rescheduled and a no show fee charged. If you are requesting our office to return medical records, you must provide a shipping label with the appropriate postage. We do not return records unless clearly noted in cover letter.

*** SEND RECORDS AND CORRESPONDENCE TO (FOR ALL LOCATIONS):**

4439 Stoneridge Drive, Suite 110, Pleasanton, CA 94588