Motor Vehicle Accident History

(Please Print)

Patient Information **Claim #_____**

Dr./Mr./Mrs./Ms./Mss. (circle one) Marital status (circle one) M S W D

_____

Last Name First Name Middle Initial Nick Name

_____

Address City State Zip Code

Home Phone #_____ Cell Phone _____ Alternate Phone _____

Cell Phone carrier (for text reminder calls):_____ E-mail_____

Social Security No._____ Date of Birth_____ Sex ☐M ☐F

Occupation_____ Employer_____

Work Address_____ Work Phone_____

Person to contact in an emergency_____ Phone #_____

Responsible Party

Name of person responsible for payment of this account_____

Relationship to patient_____ Phone #_____

_____

Address City State Zip Code

Insurance Information

Please give your photo ID and any insurance information to the staff person assisting you.

Accident/Injury History

1. Date of Injury:_____ Time of Day: _____ Road Condition: ☐ Dry ☐ Wet
2. Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat
3. Number of people in your vehicle? _____
4. Were you wearing a seat belt? ☐ Yes ☐ No *If No, go to question #6*
5. If yes, were you wearing a lap belt? ☐ Yes ☐ No Lap belt & shoulder harness ☐ Yes ☐ No
6. What direction were you headed? ☐ North ☐ South ☐ East ☐ West
   On (name of street and city):_____
7. What direction was the <u>other</u> vehicle headed? ☐ North ☐ South ☐ East ☐ West
   On (name of street and city): _____

8. Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side
   Other combination, please describe: _____

9. What was the position of your head during the collision?
   ☐ Straight Ahead ☐ Turned Right ☐ Turned Left ☐ Other_____

10. Did any part of your body strike/hit anything inside of your vehicle (steering wheel, dashboard, etc.)? ☐ Yes ☐ No If yes, please describe: _____

11. Did any items become displaced in the vehicle (rearview mirror, phone, packages, etc.)?
    ☐ Yes ☐ No If yes, please describe:_____

12. Approximate speed of your car:_____mph Estimate speed of the other car:_____mph

13. Make/model of your car:_____ Make/model of other car:_____

14. Were the police notified? ☐ Yes ☐ No Please provide this office with a copy of the police report.

15. In your own words, please describe the collision:_____
    _____

16. Did you have any physical complaints BEFORE the collision? ☐ Yes ☐ No
    If yes, please describe in detail:_____

17. Please describe how you felt:
    a. DURING the accident:_____
    b. IMMEDIATELY AFTER the accident:_____
    c. LATER THAT DAY:_____
    d. THE NEXT DAY:_____

18. Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long?_____

19. Where were you taken after the collision?_____

20. Have you been treated by another doctor since this accident? ☐ Yes ☐ No
    If yes, please list the doctor's names and locations:_____
    What type of treatment did you receive?_____

21. Did this collision occur while you were performing your regular job duties? ☐ Yes ☐ No

22. How do you feel now, what is your number one problem or the one area of greatest pain?_____

23. Please rate the level of this pain on the following scales: 0 = no pain, 10 = severe pain
    If your pain varies from day to day, please circle two numbers to indicate a range of your pain.

0 1 2 4 5 6 7 8 9 10

24. Since this injury occurred, is your pain: ☐ improving ☐ Getting worse ☐ Staying the same

25. How often do you experience the pain?

____1-2 hours per day ____About half the day ____Most of the day ____The pain never goes away

26. How does the pain affect your daily activities?
    ____It does not affect my daily activities ____I have had to change how I do things
    ____I have had to stop doing some of my daily activities ____I am unable to perform daily activities

27. What increases your pain?_____
28. What decreases your pain?_____

29. Have you ever experienced this problem before? ☐ Yes ☐ No

30. Do you have a previous illness/disease which affects your present condition? ☐ Yes ☐ No
    If yes, please describe:_____

31. List any other complaints currently bothering you and rate your pain level for each.

a. _____	0	1	2	3	4	5	6	7	8	9	10
b. _____	0	1	2	3	4	5	6	7	8	9	10
c. _____	0	1	2	3	4	5	6	7	8	9	10
d. _____	0	1	2	3	4	5	6	7	8	9	10

32. Have you lost time from work as a result of this accident? ☐ Yes ☐ No
    a. Type of employment:_____
    b. Last day worked: _____

33. Have you ever been involved in an accident before? ☐ Yes ☐ No
    a. If yes, when?_____
    b. Describe the accident(s):_____
    c. Were you injured? ☐ Yes ☐ No Explain:_____

34. List all medications you are currently taking (prescribed and over the counter):_____
    _____

35. List all surgeries you have had (with dates):_____

36. If you have experienced any of the following conditions in the past mark “P” on the line provided. If you are currently experiencing any of the following conditions mark a “C” on the line provided (check all that apply):

___heart attack	___stroke	___arthritis	___gall bladder trouble
___diabetes	___glaucoma	___fainting spells	___kidney stones
___difficulty with urination	___bloody stools	___difficulty with bowel movements	
___prostate trouble	___anemia	___cancer	___asthma
___AIDS	___ulcers	___diverticulitis	___menstrual cramps
___dizziness	___loss of memory	___chest pain	___shortness of breath
___constipation	___diarrhea	___general fatigue	___sudden weight loss
___nausea	___muscle cramping	___soreness in joints	___loss of hearing
___ears ringing	___headache	___migraine	___epilepsy
___gout	___tuberculosis	___syphilis	___sprained ankle □ R □ L
___knee/hip replacement	___broken bones (specify)	___other_____	

General Activities

37. Check all apply

___sleep on waterbed	___read in bed	___fall asleep on recliner/on couch
___sleep on stomach	___needle point/knitting	___use two or more pillows to sleep with
___sewing	___lift weights	___play video games:___hrs per day
___exercise___x per week	___jog___x per week	___computer use:___hrs per day
___swim	___watch television___hrs per day	

38. Please add anything else you would like the doctor to know:_____
_____
_____

39. Draw a diagram of the auto collision with direction and location of impact (North, East, South, West):

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services rendered on my behalf or my dependents.

Patients Signature_____ Date_____

Doctors Comments:_____

_____
_____
_____
_____
_____

ASSIGNMENT, LIEN, RELEASE & POWER OF ATTORNEY

THIS AGREEMENT, entered into this date and between _____ called "PATIENT" and Spine & Scoliosis Clinic.

WHEREAS Patient desires to receive chiropractic services from Spine & Scoliosis Clinic and desires to assign certain rights and benefits to Spine & Scoliosis Clinic as consideration for Spine & Scoliosis Clinic awaiting of such benefits.

Accordingly, it is hereby agreed:

A. Patient hereby authorizes Spine & Scoliosis Clinic to furnish a full report and records regarding case history, examination, diagnosis, treatment and prognosis, x-rays, laboratory reports and the results of all tests of any type of character of patients such persons as Spine & Scoliosis Clinic deems appropriate.

B. Patient's assigns to Spine & Scoliosis Clinic any and all benefits payable by Patient's insurance or health care plan(s) as a result of charges incurred by Patients for services rendered by Spine & Scoliosis Clinic. Patient also assigns to Spine & Scoliosis Clinic any and all contractual rights Patient has against insurance company, health care benefit plan, or any other party possibly liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by Spine & Scoliosis Clinic.

C. Patient fully understands that Patient is directly and fully responsible to Spine & Scoliosis Clinic for all bills submitted for services rendered and that this agreement is made solely for additional protection and consideration for a waiting payment. Patient further understands that such payment is not contingent on any settlement, claim, judgment, or verdict, which Patient may eventually recover. In the event of non-payment by any insurance company, health care benefit plan, or any other party possibly liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by Spine & Scoliosis Clinic, Patient agrees to be responsible for any such outstanding balance, including interest at a rate of 9%, reasonable attorney's fees and costs.

D. Patient fully understands that the lien and assignment given to Spine & Scoliosis Clinic herein is irrevocable.

E. By executing this agreement, Patient hereby instructs and directs any attorney- representing Patient to honor the above lien and assignments and make payment under the lien and assignment directly to Spine & Scoliosis Clinic. Patient directs that attorney be bound by this lien and treat it, irrevocably, as an assignment due to Spine & Scoliosis Clinic. Spine & Scoliosis Clinic is relying upon this lien, assignment and directive to any attorney, and as a result of such reliance, Spine & Scoliosis Clinic is providing care and treatment for which this lien, assignment and directive provides security for payment. *Moreover*, Patient agrees that Spine & Scoliosis Clinic is to be viewed as a third party beneficiary of this direction to Patient's attorney and it is Patient's intent to impose upon Patient's attorney an obligation to comply with the terms of this directive.

F. Patient hereby directs all insurers and other persons possibly responsible for Patient's healthcare costs to make all payments for healthcare services rendered by Spine & Scoliosis Clinic directly to Spine & Scoliosis Clinic.

G. Patient agrees that in the event Patient receives any check, draft, or other payment subject to this agreement, Patient agrees to act as fiduciary agent for Spine & Scoliosis Clinic and will immediately deliver said check, draft, or payment to Spine & Scoliosis Clinic to be applied to Patient's debt for services rendered.

H. Patient hereby appoints Spine & Scoliosis Clinic as Patient's tur and lawful attorney, irrevocable, and with full power of substitution, for Patient and in Patient's name, to ask, demand, sue for, collect, endorse, sign and receive rendered to Patient by Spine & Scoliosis Clinic. Spine & Scoliosis Clinic is not obligated or compelled to exercise such powers but may do sin in Spine & Scoliosis Clinic sole discretion. Patient agrees to fully cooperate with Spine & Scoliosis Clinic in collecting said amounts.

I. Spine & Scoliosis Clinic agrees to submit a copy of this agreement with the initial claim form(s) which Spine & Scoliosis Clinic submits to third party payor(s) as notice to the third party payor(s) of the assignment and other agreements contained herein. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in Patient's file and may be picked up by the Patient, upon reasonable request and during normal business hours, or upon written request by Patient, be mailed to designated address.

J. Patient hereby authorized Spine & Scoliosis Clinic to receive a complete copy of Patient's insurance policy, including any endorsements, conditions, limitations or exclusions.

K. A copy of these documents shall be as binding as the document bearing the original signatures.

L. Patient hereby authorizes Spine & Scoliosis Clinic to obtain a copy of any final disbursement/settlement sheet from the patient's attorney.

_____	_____
Date	Patient's Signature
_____	_____
Date	Spine & Scoliosis Clinic
_____	_____
Date	Attorney

REFERENCES:

Valley State Bank v. Dean, 97 Colo. 151, 47 P.2nd 924 (1935)
Fort Lupton State Bank v. Muranta, 626 P.2d 757 (Colo. App. 1981)
Barcucas v. Bohemia Import Co., Inc., 518 P.2d 850 (Colo. App. 1974)
Thomas v. Oken, 699 P.2d (Colo. App. 1984)

ACCEPTANCE OF PERSONAL INJURY CASE AT SPINE & SCOLIOSIS CLINIC

Here at Spine & Scoliosis Clinic we Value our quality of care we give each of our patients. Due to the volume of work load Personal Injury Cases add to the Doctor and Staff we limit our acceptance of Personal Injury Clients. Because of this limitation it is our office policy to enforce the following before taking your case:

1. You must sign a lien. A lien states that you will be responsible for your bill if for some reason your Personal Injury Case does not pay out. We do charge our full fees for all services rendered during your care under your Personal Injury Case.

2. If you do not have Personal Injury Protection (PIP) you must have an attorney.
A. Your attorney must sign our lien before care can be given.
B. You must pay $35 towards your settlement per visit unless other arrangements have been made between you and the doctor.

3. If you are an active patient your current Non-personal injury case will be placed on hold. Once the personal injury case is closed you may resume your Non-personal injury care plan. If you have a balance due on your plan you must pay in full before we will accept your personal injury case for services already rendered (unless other arrangements have been made with the Doctor).

4. You must make your appointments recommended by the Doctor. Failure to make your recommended appointments could lead to early termination of your Personal Injury Case at Spine & Scoliosis Clinic.

5. **We have a 24 hour cancellation policy in place for missed appointments.** For this reason, we ask that you place a card on file. If for some unforeseen reason you miss an appointment without 24-hour business hour notice, your card will be automatically processed for $35 for missed appointments. Your Personal injury case will not pay for these missed appointment fees and will be your responsibility.

6. Most supplements, supports, and products will not be covered by your personal injury case.

Please sign below that you have read and understand the above:

_____ _____

Signature Date