CHESTER FAMILY CHIROPRACTIC CENTER

Auto Accident Patient Intake

PATIENT INFORMATION

Name _____ **Date** _____

Address _____

City _____ **State** _____ **Zip Code** _____ **DOB** _____

Relationship Status □Single □Married □Widowed □Divorced □Separated □Partnered

Sex □ Male □ Female **How did you hear about the office?** _____

Cell Phone _____ **Home Phone** _____

Employer _____ **Occupation** _____

Have you missed any days at work? □ Yes □ No **Dates Missed:** _____

Date of Accident _____ **Time of Accident** _____**AM/PM**

Were you the:

□ Driver □ Front Passenger □ Rear Passenger Right □ Rear Passenger Left □ Pedestrian

Emergency Contact _____ **Phone** _____ **Relationship** _____

ACCIDENT SITE

Road/Street Name _____

City/State _____

Driving Conditions: □ Dry □ Wet □ Icy □ Other

Visibility: □ Poor □ Fair □ Good □ Other_____

Was your vehicle moving? □ Yes □ No

Speed of you vehicle: _____**mph**

YOUR VEHICLE

Make and model of your car:_____

Were you wearing a seatbelt? □ Yes □ No

Were shoulder harnesses worn? □ Yes □ No

Did the airbag inflate? □ Yes □ No

Did your seat have a headrest? □ Yes □ No

If yes, what was the position of the headrest?

□ Top of headrest even with **bottom** of head

□ Top of headrest even with **top** of head

□ Top of headrest even with **middle** of neck

OTHER VEHICLE

Make and model other vehicle _____

Speed of other vehicle _____**mph**

IMPACT

Did your car impact another vehicle? □ Yes □ No

Did your body strike anything inside the vehicle?

□ No □ Yes, explain_____

Type of Impact: □ Front □ Rear □ Left

□ Right □ Other _____

How were you sitting before impact?

□ Head straight forward □ Body Straight

□ Head up/down □ Body Rotated right/left

□ Head turned right/left □ Other

Did you see the accident coming? □ Yes □ No

Did you brace for impact? □ Yes □ No

Was your car braking? □ Yes □ No

ILLUSTRATION OF THE ACCIDENT

PATIENT CONDITON

Were you unconscious after the accident? ◻ Yes ◻ No **If yes, for how long?**_____

Could you move all parts of your body? ◻ Yes ◻ No **If no, which parts couldn't you move and why?**_____

Were you able to get out of the car and walk unaided? ◻ Yes ◻ No, why not? _____

Did you get any bleeding cuts? ◻ Yes ◻ No **If yes, where?**_____

Did you get any bruises? ◻ Yes ◻ No **If yes, where?** _____

Please describe how you felt, 1) immediately after the accident?_____

2) Later that day?_____

3) The next day?_____

TREATMENT

Did you go to the hospital immediately after the accident? ◻ Yes ◻ No

How did you get there? ◻ ambulance ◻ police ◻ someone else drove me ◻ drove own car

When did you go? ◻ Immediately after the accident ◻ Next day ◻ 2 days or more after the accident

Hospital Name: _____ **Name of Doctor :** _____

Treatment received: _____

Medications given: _____

X-rays taken: _____

Did you seek any additional treatment? ◻ Yes ◻ No **If yes, who did you see?** _____

Date of visit?_____ **Treatment received:** _____

SYMPTOMS

If you have had any of the following symptoms since the accident, please check off:

Rate each symptom with a number on a scale of 0-10 with 10 being the worst.

◻ **Arm/Shoulder pain**	◻ **Foot/toe numbness**	◻ **Dizziness**
◻ **Low back pain**	◻ **Neck stiffness**	◻ **Ear ringing**
◻ **Neck pain**	◻ **Headaches**	◻ **Memory Loss**
◻ **Upper back pain**	◻ **Irritability**	◻ **Jaw problems**
◻ **Chest pain**	◻ **Nausea**	◻ **Sleep difficulty**
◻ **Leg pain**	◻ **Stomach upset**	◻ **Blurred vision**
◻ **Hand/finger numbness**	◻ **Chest pain**	◻ **Shortness of breath**

Past health history: Place an x if it applies and describe:

◻ None related to current complaints	◻ Hospitalized	◻ Surgery
◻ Other auto accident(s)	◻ Work Accident	◻ Illness

I certify my insurance benefits, if any, to be assigned directly to CFCC. I understand that I am responsible for all charges whether or not paid by insurance. I authorize CFCC to use my health care information and may disclose such information to the provided insurance company(ies) and their agents for the purpose of obtaining payment for services determining insurance benefits or the benefits payable for related services.

PATIENT SIGNATURE _____ **DATE** _____

The Rivermead Post-Concussion Symptoms Questionnaire

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one, please circle the number closest to your answer.

0= Not experienced at all
1= No more of a problem
2= A mild problem
3= A moderate problem
4= A severe problem

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

Headaches.....	0 1 2 3 4
Feelings of Dizziness	0 1 2 3 4
Nausea and/or Vomiting	0 1 2 3 4
Noise Sensitivity, easily upset by loud noise	0 1 2 3 4
Sleep Disturbance	0 1 2 3 4
Fatigue, tiring more easily	0 1 2 3 4
Being Irritable, easily angered	0 1 2 3 4
Feeling Depressed or Tearful	0 1 2 3 4
Feeling Frustrated or Impatient	0 1 2 3 4
Forgetfulness, poor memory	0 1 2 3 4
Poor Concentration	0 1 2 3 4
Taking Longer to Think	0 1 2 3 4
Blurred Vision	0 1 2 3 4
Light Sensitivity, Easily upset by bright light	0 1 2 3 4
Double Vision	0 1 2 3 4
Restlessness	0 1 2 3 4

Are you experiencing any other difficulties?

1. _____	0 1 2 3 4
2. _____	0 1 2 3 4

Patient Signature _____

Date _____

Personal Injury Information

ATTORNEY INFO

Have you obtained an attorney? ☐ Yes ☐ No

If so:

Attorney Name _____ Office Name_____

Phone Number _____ Fax Number _____

YOUR AUTO INSURANCE INFORMATION (Or OWNER OF VEHICLE)

Do you have MedPay on your policy? ☐ Yes ☐ No

Name of Insured _____
(IF OTHER THAN YOURSELF)

Name of Insurance Company _____

Claim Number _____

Claim Adjuster _____

Contact Number _____Ext_____

Address _____
_____

Have you had/ have you been scheduled for an independent medical exam? ☐ Yes ☐ No

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OTHER DRIVERS AUTO INSURANCE INFORMATION

Name of Insured _____
(IF OTHER THAN YOURSELF)

Name of Insurance Company _____

Claim Number _____

Claim Adjuster _____

Contact Number _____Ext_____

Address _____
_____

Patient Consent Form

Regarding the Use and Disclosure of Protected Health Information

For the purpose of this Consent Form, "Office" shall refer to Chester Family Chiropractic Center.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy entitled "Our Privacy Practices". I understand that I may review this privacy notice at any time prior to signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice revised, I can call the Office to request a copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this consent in, but only to the extent that the office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in my writing.

Your signature also allows us to discuss or release any medical/financial information to the person(s) you choose to authorize below.

Patient name (Please Print)_____

Signature_____

Date___/___/_____

Authorization to (Please Print) _____

Relationship_____

Date___/___/_____ Revoked Date___/___/_____

Authorization to (Please Print) _____

Relationship_____

Date___/___/_____ Revoked Date___/___/_____

IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORIZATION AND LIEN

To Whom It May Concern:

This Irrevocable Assignment of Benefits, Authorization and Lien is made by and between _____(Patient) and Chester Family Chiropractic Center. With this Assignment, and in consideration of treatment without having to render concurrent payment, Patient, hereby irrevocably transfers sets over and assigns to Health Care Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the Patient by reason of accident or illness, including 2% interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorney's fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to Patient or on Patients behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, personal injury protection benefits, third-party liability coverage, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patients favor as may be necessary to fully pay any and all financial obligations owed to the Health Care Provider by the Patient. This Assignment is to be a complete and current transfer of Patients right, title, and interest, separate from any statutory or contractual lien or claim to which the Health care Provider may also be entitled. Patient acknowledges that Health Care Provider has a substantial pecuniary interest in the enforcement of this Assignment.

The Patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Providers total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Health Care Provider any and all causes of action that Patient might have or that might exist in Patients favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates and appoints as Patients attorney-in-fact any officer of Health Care Provider, to prosecute said causes(s) of action either in Patients name or in the Health Care Providers name and Patient further authorizes the Health Care Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Health Care Provider, Patient hereby grants a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Health Care Provider. The Patient further agrees that the statute of limitations applicable to Health care Providers right to demand payment from the patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing.

Patient hereby acknowledges that Virginia law imposes a lien in the amount of $750.00 upon Patients claim against the individual or entity whose negligence is alleged to have caused Patients injuries.

Notwithstanding the foregoing, the Patient agrees that until the Health Care Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due the Health Care Provider (including principal, 2% interest, collection costs and attorney's fees of 40%) until fully paid. The Patient further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect payment, it may demand payments from Patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

Patient authorizes the Health Care Provider to release this Assignment and any information pertinent to Patients case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Health Care Provider as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of the services provided to Patient by said Health Care Provider.

In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect.

Notice regarding the assignment of medical expense benefits is provided in a separate document. I have been presented with and had an opportunity to read the notice. Acknowledged: _____(patient initials)

Witness the following signatures and seal as of the indicated date:

Patients Signature _____

Printed Name_____ Date____/____/_____

SSN #_____

Witness_____ Date____/____/_____

Health Care Provider

Chester Family Chiropractic Center

By:

It's Owner

Date ____/____/_____