PERSONAL INJURY QUESTIONNAIRE

NAME: ____ DATE OF ACCIDENT: ____________________

Where did accident happen? Please describe the accident in your own words:

What was your position in the car?

____ Driver: Where were your hands on the steering wheel? Left ___ Right ___ Both ___

____ Passenger: Where were you sitting? Front ___ Right Rear ___ Left Rear ___ Center Rear ___

Did your vehicle strike another vehicle? Yes ___ No ___

Was your vehicle struck by another vehicle? Yes ___ No ___

Angles of impact: 1st Collision: Front ___ Back ___ Left ___ Right ___

2nd Collision: Front ___ Back ___ Left ___ Right ___

Were you wearing a seat belt? Yes ___ No ___

Did you brace for impact? Yes ___ No ___ If yes: Braced with my hands ___ with my feet ___

Which way were you facing at the time of impact? Straight ahead ___ Left ___ Right ___

Did you strike anything in vehicle at time of impact? Yes ___ No ___

If yes, specify what part of your body struck what (ie… head, chest, shoulder, knee, & right or left):

Steering Wheel ___________________________ Dashboard __________________________

Windshield ______________________________ Roof _______________________________

Left Side Door ____________________________ Right Side Door _______________________

Left Side Window __________________________ Right Side Window _____________________

Other ____

Did the seat belt bend or break? Yes ___ No ___

Immediately following the accident, how did you feel? Dizzy/dazed __ Disoriented __ Unconscious __ Nervous __

Nauseous __ Upset __ Weak __ Other ____

Did you go to hospital? Yes ___ No ___ Were you admitted? Yes ___ No ___ If yes, for how long? ___

If you went to hospital, when? At time of accident ___ Next day ___

How did you get to hospital? Ambulance ___ Police Car ___ Private Transportation ___

Name of Hospital: ____

Attended by Doctor: ____

What treatment was given?

none ___ placed in a cervical collar ___ x-rayed ___ given stitches ___ bandaged ___

given pain medication ___ given instructions regarding concussions ___

given instructions regarding sprains and strains ___ physical therapy ___

instructed to call an Orthopedic Surgeon ___ instructed to call a private physician ___

referred to this office for treatment ___ Other ____

____

Have you seen any other doctor as a result of this accident? Yes ___ No ___

Doctor's Name / Info: ____

Patient Name:____ DOB:___________________ ACCT:___________

CHIEF Complaints or Symptoms: **Name: ____________________________** **Date: ___________**

Neck Pain? Yes ___ No ___

If yes, check off the areas that the pain runs from the neck:

Left Shoulder ___ Left Arm ___ Left Forearm ___ Left Hand ___ Headaches ___

Right Shoulder ___ Right Arm ___ Right Forearm ___ Right Hand ___ Upper Back ___

Ringing in Ears? Yes ___ No ___ if yes: Left ____ Right ____ Both ____

Blurred Vision? Yes ___ No ___ if yes: Left ____ Right ____ Both ____

Wrist Pain? Yes ___ No ___ if yes: Left ____ Right ____ Both ____

Jaw Pain? Yes ___ No ___ if yes: Left ____ Right ____ Both ____

Low Back Pain? Yes ___ No ___

If yes, check off the areas that the pain radiates to:

Both Buttocks ___ Left Buttock ___ Left Thigh ___ Left Knee ___ Left Foot ___

Right Buttock ___ Right Thigh ___ Right Knee ___ Right Foot ___

Hip Pain? Yes ___ No ___ if yes: Left ____ Right ____ Both ____

Knee Pain? Yes ___ No ___ if yes: Left ____ Right ____ Both ____

Foot Pain? Yes ___ No ___ if yes: Left ____ Right ____ Both ____

Numbness?

Hands? Yes ___ No ___ if yes: Left ____ Right ____ Both ____

Upper Arms? Yes ___ No ___ if yes: Left ____ Right ____ Both ____

Legs? Yes ___ No ___ if yes: Left ____ Right ____ Both ____

Feet? Yes ___ No ___ if yes: Left ____ Right ____ Both ____

Other:

Dizziness___ Nervousness___ Fatigue___ Anxiety___ Depression___ Excessive Irritability___

Fear of Driving___ Loss of Concentration___ Jaw Clenching___ Grinding Teeth___ Nightmares ___

Difficulty sleeping___

Additional Symptoms / Complaints:

____

____

____

____

____

____

Have you lost any time from work due to your injuries? Yes ___ No ___

If yes, please provide dates: ____

Type of employment? ____

Have you had previous injuries or accidents? Yes ___ No ___

If yes, please describe previous injuries: ____

Please describe previous accidents: ____

Is there any residual pain from the previous injury? Yes ___ No ___

How much better did you feel prior to your current condition? (Example 100%, 80%, etc.): _______________

Patient Name:__________________________________ DOB:__________________ ACCT:___________

Check List for Personal Injury

To accept your personal injury case we need all of the following:

____ Attorney's Name____________________________________
Attorney's Phone____________________________________

____ A copy of the Police Report or Exchange Slip

____ Liability Information (Responsible Parties Insurance)
Insurance Company__________________________________
Claim #____
Policy #____
Phone #____

____ Your Personal Auto Insurance Company
Insurance Company__________________________________
Claim #____
Policy #____
Phone #____

____ Records / X-Rays from any other doctor seen for this accident
Doctor's Name______________________________________
Doctor's Office/Hospital_______________________________

Please Initial Your Section

_____ I wish to use my personal health insurance and pay my own bill for treatment.

- I understand I am responsible for paying my copayment, deductible and/or coinsurance amount at the time services are rendered.
- I also understand if my health insurance denies claims for any reason that I will be responsible for balance due.

____ I wish for Crossroads Family Chiropractic to extend me credit for services rendered and accept assignment to be reimbursed by the insurance listed above.

____ I choose to have an attorney to handle my case and have all of my bills send to him/her.
____ I choose to have an insurance adjuster to handle my claim and have all my bills sent to him/her.

I understand that if I do not complete the above information, I will be held responsible for payments of services rendered at Crossroads Family Chiropractic. I also understand that if I do not receive compensation from a liability source that I am responsible for payment in full to our office.

Patient Signature:____ Date:_____________ Front Desk:_________

Patient Name:____ DOB:___________________ ACCT:___________

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of Crossroads Family Chiropractic treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to Crossroads Family Chiropractic any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on __________________________ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to Crossroads Family Chiropractic, from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers' compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due or may become due to Crossroads Family Chiropractic for its services rendered.

I appoint Crossroads Family Chiropractic as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance may have with Crossroads Family Chiropractic.

I authorize Crossroads Family Chiropractic to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to Crossroads Family Chiropractic for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If Crossroads Family Chiropractic is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Crossroads Family Chiropractic for its costs of recovery, including reasonable attorney's fees.

____
Patient

____
Date

____
Witness

NOTICE OF LIEN

Pursuant to N.C.G.D. 44-49 and 44-50, Crossroads Family Chiropractic hereby asserts and give notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for settlement of injuries sustained, whether in litigation or otherwise.

Crossroads Family Chiropractic hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. Crossroads Family Chiropractic agrees to be bound by any confidentially agreements regarding the contents of the accounting.

CROSSROADS FAMILY CHIROPRACTIC

By:______________________________________

Patient Name:____ DOB:____________________ ACCT:___________

Personal Injury / Workman's Compensation

Office Policy

It has been our experience that it is wise to have a complete understanding with our patients of our office policy. It is important for you to know the office policy, fees, and insurance billing procedures. If you have been involved in an auto accident, or related injury, and have insurance that covers medical expenses at 100% we will gladly accept your case with the following regulations.

- If you have an attorney, notify us as soon as possible and ask him/her to send us a letter of representation. A release packet including your bills and records will be sent to the attorney for you after your release.

- If you do not have an attorney you will need to ask the adjuster to contact our office and provide all information for billing the insurance company. No bills or copies of bills will be given to you or the insurance company until your adjuster has called and given us an indication that they will do everything possible to protect the doctor's interest.

- When your case has been settled and all medical bills paid, if an overpayment exists on your account (due to having more than one insurance company) we will forward the overpayment to you as a credit to our clinic or a payment to you. A written request must be submitted to our office before a refund check can be issued. **If your bill is not PAID IN FULL, you will be responsible for the remainder of the balance.**

- You will need to provide our office with all insurance information (Personal Auto and Health) to ensure that the bill gets paid.

- If you have Medpay, you will need to let your insurance company know that we will be filing your bills under that policy to ensure that your balance is paid in full. In the event that your account is overpaid, you will be refunded after your case is settled. And in the event that the balance is underpaid, you will be responsible for the remaining balance.

By signing below, I am stating that I have read the above and do understand I will not be presented with copies of bills until proper procedures have been followed. Crossroads Family Chiropractic will honor the lien signed and hold your bill, so there is no cost to you in an agreement that we will be treated fairly in the settlement process.

Thank You!

Patient Signature:______________________________________ Date:__________ Front Desk:_________ Date:___________

CROSSROADS FAMILY CHIROPRACTIC
DR. RYAN L WILLIAMS
58 OLD ROBERTS RD BENSON, NC 27504
PHONE: (919)-989-1888 • FAX: (919)-989-1898

Patient Name:____ DOB:____________________ ACCT:___________

Crossroads Wellness & Rehab

Election Not to File Health Insurance Claims
(Personal Injury/Accident)

The chiropractor(s) at this clinic are participating ("in-network") providers for your health benefit plan. As participating providers, we are obligated to file claims for reimbursement with your plan for all covered services provided to you UNLESS you instruct us in writing not to file.

You have indicated that for services related to this personal injury, rather than using your own health insurance, you wish to consider seeking payment from other third-party payors such as the at-fault driver's liability insurance. To help you make an informed decision, please carefully review the following information.

If you elect NOT to file claims on your health insurance:

1. The clinic will rely on your decision and extend credit to you for the cost of care based on the assumption that your bill will be paid by sources other than your health insurance. **You will be required to assign to the clinic the right to receive monies paid by liability insurers, medical payments insurers or other third-party payors to the extent necessary to satisfy your bill.**
2. You will not be required to pay co-payments/co-insurance and/or deductibles that would normally be required by your health benefit plan.
3. The cost of your treatment will be billed at the clinic's usual rates rather than the discounted rates that routinely apply to services covered by your health benefit plan.
4. If the combined payments received from other sources do not fully satisfy your bill, you may be personally liable for any unpaid balance.
5. None of the charges for your treatment will be applied towards satisfying the annual deductible (if applicable) associated with your health benefit plan.

If you elect TO file claims on your health insurance:

1. Your health insurance should pay the cost of *covered* services associated with this accident/injury EXCEPT FOR copayments, co-insurance and/or deductibles, which you will be expected to pay directly to the clinic at the time services are rendered.
2. You will be responsible for paying to the clinic the cost of any *non-covered* services you elect to receive, and your payment will be due at the time services are rendered.
3. If your health benefit plan initially pays the clinic for your treatment and later determines that it is not legally responsible for payment, the plan administrator may require the clinic to refund to the plan all or part of the payments received. If that happens, you will become responsible for reimbursing the clinic the amount it was required to refund.

4. Your health benefit plan requires the clinic to submit claims in a timely fashion and while timely filing requirements vary, most plans require claims to be filed within 3-6 months from date of service. If your action or inaction causes a claim to be submitted late, the claim could be denied, and you would be responsible for paying this clinic for those services which were denied.

Election not to file health insurance claims:

1. By my signature below, I attest that I have read and understand the above information regarding the options available to me and have been given an opportunity to ask questions and to have those questions answered.
2. I hereby instruct the clinic not to file claims on my health insurance for services associated with this accident/injury, and I authorize the clinic to seek payment from, and send my treatment records to, other third-party payors who are potential sources of payment.
3. I understand that the clinic is relying on my decision not to file health insurance claims, and that with regards to claims related to this accident/injury, this decision is irrevocable.
4. I understand that no subsequent action on my part shall impair the clinic's right to bill and receive payments from third-party payors; subject only to any contractual obligation the clinic may have to my health benefit plan.

____
Printed Name of Patient

____
Signature of Patient
(or parent/legal guardian, as applicable)

____
Date:

____
Printed Clinic Representative

____
Signature of Clinic Representative

____
Date:

A complete copy of this executed agreement must be maintained in the patient's health care record, and a copy must be provided to the patient.