

Healing Hands Chiropractic Automobile Accident Questionnaire

Full Name: _____ Date: ____/____/____

Date of Accident: ____/____/____ Time of Accident: ____:____ AM/PM

Driver of Car: _____ Owner of Car: _____

Year/Make/Model of Car: _____

Where you were seated at time of accident: _____

Visibility at time of accident: Poor / Fair / Good / Other _____

Road conditions at time of accident: Icy / Rainy / Wet / Clear / Dark / Other _____

Where was your car struck?: Right / Left / Front / Rear / Side / Other _____

Type of accident: Head on collision Broad side collision Rear end collision Front Impact, rear ended car in front
Non-collision _____

What part of the car was damaged?: _____

Describe what happened to you upon impact: _____

Did you see that the accident was about to happen? Yes No

Did you brace for impact? Yes No

Were you wearing a seatbelt? Yes No

Does the car have headrests? Yes No

If yes, what part of your head was even with the top of the headrest? bottom of head middle of head top of head

Was your car breaking? Yes No Was the other car breaking? Yes No

Was your car moving at the time of the accident? Yes No

If yes, how fast would you estimate you were travelling? _____

How fast would you estimate the other car was travelling? _____

What was the position of your head at the time of impact? Head straight forward Head turned left/right
Head looking back Other _____

What was the position of your body at the time of impact? Body straight in sitting position Body rotated left/right
Other _____

At the time of the accident, recall what parts of your head or body hit what parts of the vehicle: _____

As a result of the accident were you Dazed Rendered unconscious Other _____

Could you move all parts of your body? Yes No

If no, why not? _____

Were you able to get out of the car and walk unaided? Yes No

If no, why not? _____

Did you have any cuts or bruises from this accident? Yes No

If yes, where? _____

Describe how you felt immediately after the accident? _____

How did you feel later that day night? _____

How did you feel the next day(s)? _____

Check all symptoms apparent since the accident:

Headache	Numbness in fingers	Mid back pain	Loss of memory
Loss of taste	Loss of smell	Fatigue	Diarrhea
Cold feet	Cold hands	Pain behind eyes	Shortness of breath
Tension	Low back pain	Irritability	Nervousness
Chest pain	Constipation	Loss of balance	Sleeping Problems
Fainting	Dizziness	Numbness in toes	Other (Please List Below)
Cold sweats	Depression	Eyes sensitive to light	
Ringing/buzzing in ears	Anxious	Neck pain/stiffness	

Have you missed time from work? Yes No Work Status: Full Time Part Time Unemployed

If you have missed time from work, how much time have you missed? _____

Did the accident occur during your work hours? Yes No

Did you seek medical help after the accident? Yes No

If yes, how did you get there? _____

Doctor/hospital/clinic seen: _____ Date: ____/____/____

What was done? _____

Were X-Rays taken? Yes No If so, of what body part? _____

What treatment/prescriptions were given? Bed rest Brace Adjustments Medications None of the above

What benefit(s) did you receive from treatment(s)? _____

Date of last treatment: ____/____/____

Are any of your activities of daily living any different now compared to before the accident? Yes No

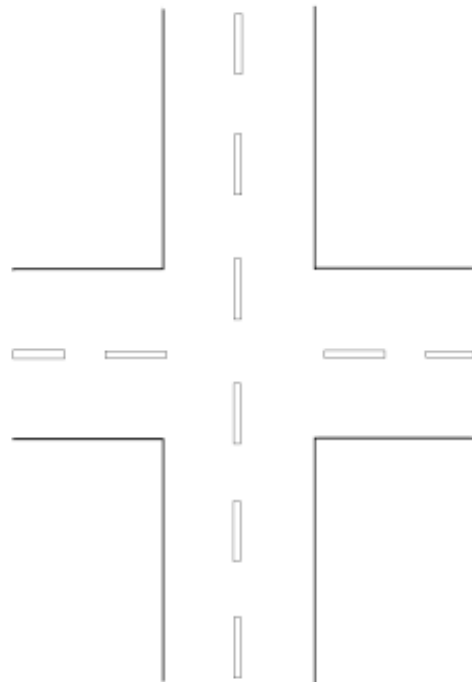
List anything you are unable to do: _____

List anything that is painful to do: _____

List anything that is difficult to do: _____

Indicate on the diagram below how the accident happened and make any necessary comments or explanations:

Comments: _____



Do you have an attorney handling this case? Yes No

If so, who? (name and address) _____

Insurance Information

Patient's personal car insurance company: _____

Policy #: _____ Insurance Phone #: (_____) _____ - _____

Insurance address: _____

City: _____ State: _____ Zip Code: _____

Claim #: _____ Adjustor's name/phone: _____

Other party's car insurance company: _____

Patient's personal car insurance company: _____

Policy #: _____ Insurance Phone #: (_____) _____ - _____

Insurance address: _____

City: _____ State: _____ Zip Code: _____

Claim #: _____ Adjustor's name/phone: _____

Major medical health insurance company: _____

Policy #: _____ Insurance Phone #: (_____) _____ - _____

Insurance address: _____

City: _____ State: _____ Zip Code: _____

Assignment of Payment

My attorney and /or insurance carrier are hereby requested to pay direct to Healing Hands Chiropractic any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Healing Hands Chiropractic the difference, if any, between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is additionally understood that I, the undersigned, agree to pay Healing Hands Chiropractic the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Print Full Name: _____

Signature: _____ Date: ____/____/____

Witness: _____

HEALING HANDS CHIROPRACTIC

Damien Rodulfo, D.C., C.C.S.P.
2105-C W Cornwallis Dr.
Greensboro, NC 27408
(336) 235-4530
Fax (336) 235-0754

To any insurance company with coverage applicable to my claims and to any attorney representing us:

Assignment of Benefits

In consideration of the willingness of Healing Hands Chiropractic to treat me on credit without demand of payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to Healing Hands Chiropractic any proceeds or compensation that I am or may be 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 Healing Hands Chiropractic, from any disability 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 as are due or may become due to Healing Hands Chiropractic for its services rendered.

I appoint Healing Hands 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 named as payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Healing Hands Chiropractic.

I authorize Healing Hands Chiropractic to release any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries or prior medical history 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 Healing Hands Chiropractic for services rendered, including any balance remaining after the application of insurance payment and settlement or judgment proceeds. If Healing Hands Chiropractic is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Healing Hands Chiropractic for its costs of recovery, including reasonable attorney's fees.

Patient's Full Name _____

Patient's Signature _____ Date ____/____/____

Parent or Legal Guardian _____ Date ____/____/____

Witness _____ Date ____/____/____

Notice of Lien

Pursuant to N.C.G.S. 44-49 & 44-50, Healing Hands Chiropractic hereby asserts and gives notice of a lien upon any sums recovery in damages for personal injury in any civil action and also upon all funds paid to above-names patient in compensation for or in settlement of injuries sustained, whether in litigation or otherwise. Healing Hands Chiropractic hereby requests that if its claims are not paid in full from the foregoing proceeds, a full disclosure and accounting proceeds be provided in conformity with N.C.G.S. 44-50.1. Healing Hands Chiropractic agrees to be bound by any confidentiality agreements regarding the contents of accounting.

Authorizations and Releases

Name: _____

Consent to Professional Treatment

I certify that all information provided to this practice is true and correct to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care of treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am a legal guardian of the child, and grant my consent for a treatment of the child as provided for herein. I acknowledge that I may refuse treatment at any time.

Initial: _____

Consent to Perform and Interpret X-Rays

I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of this practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient, and I hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate.

I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree that any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor.

Initial: _____

Females: Consent to X-Ray During Pregnancy

This is to certify that I am or may be pregnant and that a doctor or certified staff have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis can be hazardous to a fetus.

Initial: _____

Assignment of Benefits and Release of Records

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health care plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable.

I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.

Initial: _____

Financial Obligations

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where in my liability is limited by contract of State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.

Should the account be referred to an attorney for collection, I shall pay fees, including, but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health coverage.

You may direct any questions regarding this financial obligation to the clinic manager or physician.

Initial: _____

Signature: _____ Date: ____/____/____