FOUNDATION

Family Chiropractic

PERSONAL INJURY QUESTIONNAIRE

Legal Name ______________________________ Name you go by ______________ Date __________

Address ______________________________ City ____________________ State _______ Zip ___________

Age _________ Birthdate ______________ Sex ( )F ( )M Email: ________________________________

Home Phone ____________________ Work Phone _____________________ Cell Phone ____________________

Your Auto Insurance Information

Auto Ins. Co. ______________________________ Claim # ______________________________

Address ______________________________ City ____________________ State _______ Zip ______________

Adjuster's Name ____________________________ Adjuster's Phone # ______________________ Ext. ________

Policy Holder's Name (if other than self)____

Accident Details

Date of accident: _______ Time of day: ______ am/pm Were you struck from: *Behind Front Left Right*

Does car have a headrest? *( ) Yes ( ) No* Headrest height at impact? *Bottom of head Bottom of Neck Middle of head*

Number of people in vehicle:_____ Were you wearing a seat belt? *( ) Yes ( ) No* Were you: *Driver or Passenger?*

Were you in the *front seat* or *back seat*? Approx speed of your car:____ mph Approx speed of other car:___ mph

Were you knocked unconscious? *( ) Yes ( ) No If yes, for how long?* ____ Were the airbags deployed? *( ) Yes ( ) No*

Were the police notified? *( ) Yes ( ) No* Do you have an accident report? *( ) Yes ( ) No* *please provide a copy

Was a traffic violation issued? ( ) Yes ( ) No If yes, to whom: ____

Were there witnesses? If so, please name: ____

In your own words, please describe the accident:

____

____

____

Did you have any physical complaints before the accident? ( ) Yes ( ) No
If yes, please describe: ____

Please describe how you felt:
During the accident ____

Immediately after the accident ____

Later that day ____

Have you been treated by another doctor since the accident? ( ) Yes ( ) No
If yes, please write down their names: ____

Since the injury occurred, are your symptoms ( ) improving ( ) getting worse ( ) the same

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:
( ) Headache ( ) Irritability ( ) Numbness in toes ( ) Flushed face ( ) Neck pain
( ) Chest pain ( ) Back Pain ( ) Shortness of breath ( ) Buzzing in ears ( ) Stiff neck
( ) Dizziness ( ) Fatigue ( ) Loss of balance ( ) Fainting ( ) Depression
( ) Diarrhea ( ) Heavy Head ( ) Memory Loss ( ) Loss of Taste ( ) Fever
( ) Cold Feet ( ) Cold Hands ( ) Ringing in ears ( )Constipation ( ) Loss of smell
( ) Nervousness ( ) Pin/Needles in legs ( )Difficulty breathing
( ) Numbness in fingers ( ) Pins/Needles in arms ( ) Upset stomach
( ) Light Sensitive Eyes ( ) Other _________________ ( ) Other ___________________

Have you ever been involved in an accident before? ( ) Yes ( ) No
If yes, please describe, including dates and types of accidents as well as injuries suffered:

____

Have you lost time from work as a result of this accident? ( ) Yes ( ) No
If yes, last day worked:

Type of Employment:_________________ Place Of Employment: _________________________

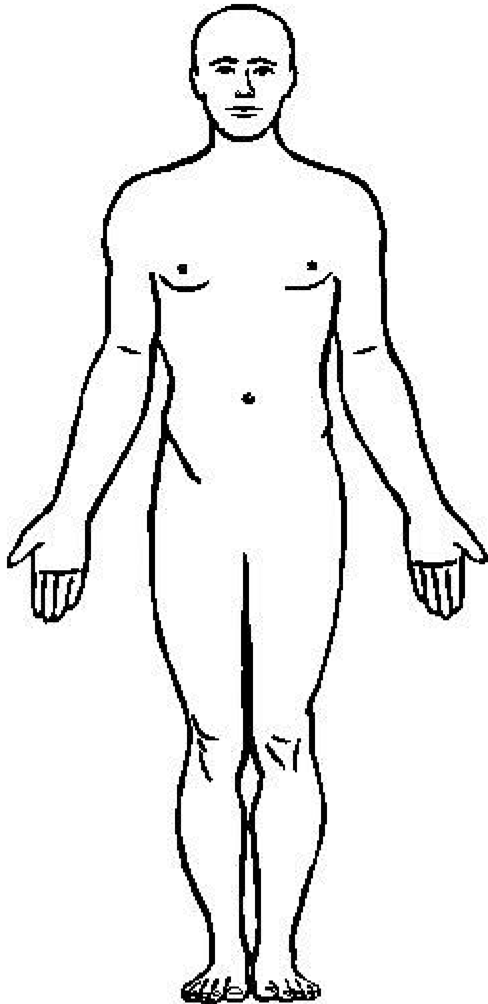
Did you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No
If yes, please describe: ____

____

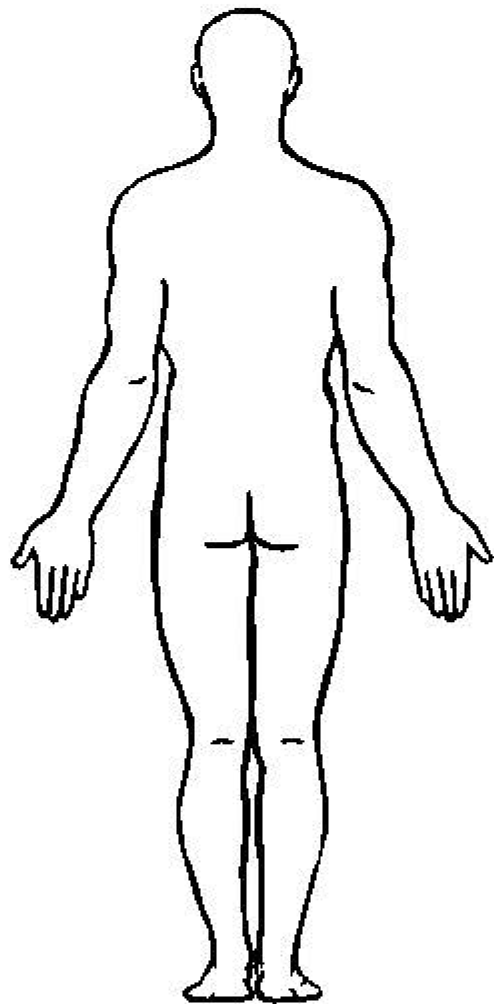
General Symptoms Sheet

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE	G = STABBING	N = NUMBNESS
B = BURNING	M = SPASMS	T = TINGLING
P = PINS & NEEDLES	F = STIFFNESS	O = OTHER



FRONT



BACK

If you marked “O” for OTHER on any part, please explain below:

____

____

____

____

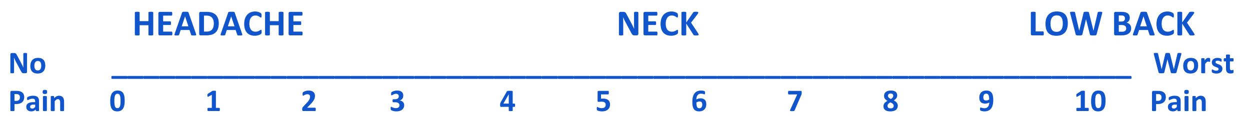
QUADRUPLE VISUAL ANALOGUE SCALE

Name ____ **Date** __________

INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each Individual complaint and indicate which score is for which complaint.

EXAMPLE:



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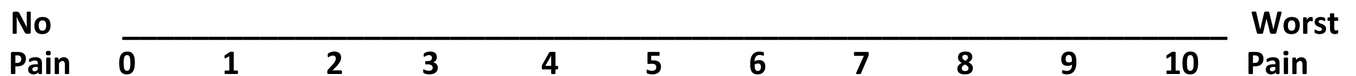
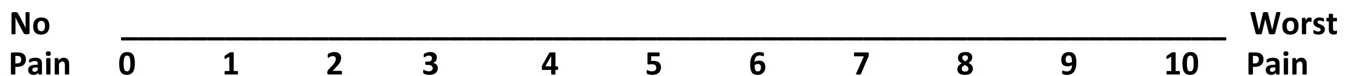
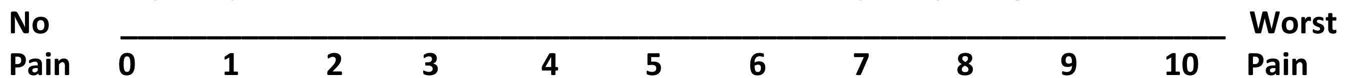
1. What is your pain RIGHT NOW?



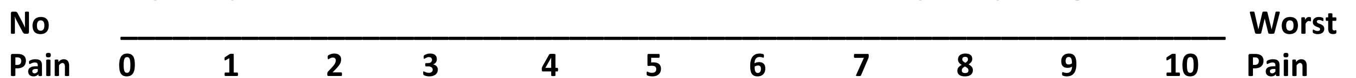
2. What is your TYPICAL or AVERAGE pain?



3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?



4. What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?



PERSONAL INJURY OFFICE POLICY

We would like to take this opportunity to welcome you to the office and assure you that you will receive the very best care available for your injury. In order to familiarize you with the financial policy of our office, we would like to explain how your medical bills will be handled. Please initial where indicated and sign below that you have read and understand this policy.

Responsibility for Accident

If you were involved in an auto accident, that you were responsible for, in your own vehicle, we will bill your medical portion of your car insurance policy (if available) for services rendered in our office. If you were a passenger in another vehicle, the car insurance company that insures that vehicle may be billed for the charges of your medical services.
If another vehicle, other than the vehicle you traveled in, caused the accident, we will first bill your auto insurance for medical services rendered. If your car insurance policy does not include a medical pay portion, we will require that you sign a lien and obtain an attorney. By signing the lien we agree, as a courtesy to you, to defer payment of your medical bills until your settlement is received. If care is discontinued before your treatment plan is complete, payment of your account is due immediately. This office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

____

Your initials

Responsibility for Payment

If you already have an attorney, please provide the name and contact info on the sheet provided. Ask your attorney to send us a letter of representation. A release packet including your bills and records will be sent to your attorney after your release exam. If you do not plan to retain an attorney and are, instead, filing claims to an insurance company, you will need to contact the insurance company and provide us with all information for billing including name, contact information and claim number. No bills or copies of bills will be given to you until the attorney or insurance company has given us an indication that they will do everything possible to protect the interest of Foundation Family Chiropractic. As a courtesy to you, we will provide your insurance company and/or attorney with all the information they might need to negotiate and provide payment for any charges you occur in our office. However, all charges for services rendered in our office are charged directly to you and ultimately you are personally responsible for payment of these charges.

____

Your initials

Cancellation & No-show Policy

Appointments you schedule are reserved especially for you. If you need to reschedule or cancel an appointment, we request and appreciate a minimum of 24-hours notice. If it is necessary to miss an appointment, we request that you make the appointment up, within 24 hours, if possible. Patients who miss 3 consecutive visits without calling this office will be discharged from care. Your claim will be closed out and bills submitted to the appropriate insurance company or the attorney listed on your patient intake form.

____

Your initials

I hereby authorize and direct my attorney or insurance company to pay to Foundation Family Chiropractic such sums as may be due for chiropractic services rendered me by reason of the accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate Foundation Family Chiropractic . And I hereby further request that payment be made directly to Foundation Family Chiropractic which would otherwise be paid to myself, as the result of the treatment charges injured for the injuries in connection therewith. This is a direct assignment of my rights and benefits under this claim. I understand that I am directly and fully responsible for all medical bills submitted for services rendered me and that this agreement is made solely for the protection and in consideration Foundation Family Chiropractic for awaiting payment. And I further understand that such payments are not contingent on any settlement, judgment or verdict which I may eventually recover. Please acknowledge your agreement to this request by initialling above and signing below.

___________	___________________	___________________________	____________
Date	**Patient's Name**	**Signature**	**Date of Injury**

Dr Kyle Heimer, DC
Foundation Family Chiropractic

455-A Old Trolley Road Summerville, SC 29485
843-851-2417 (phone) 843-875-3817 (fax)
EIN: 81-3609472

<u>Letter of Protection / Irrevocable Assignment of Benefits</u>

Patient's Name: ______________________If Minor, Guardian or Responsible Party: _____________________

Accident Date: __________________ Attorney's Name: ____

Law Firm Name and Address: ____

____

I, ________________________, do hereby authorize this office to furnish the above listed attorney and/or insurance company, with a full report of my examination, diagnosis, treatments, prognosis etc., in regard to the accident in which I was involved.

I hereby direct my attorney to withhold the full amount for the billed charges in connection to this accident. I hereby notify my attorney that I have a lien from the above provider's office in consideration of their willingness to treat me on credit without demand for payment at the time services are rendered. I instruct my attorney to pay for all services rendered directly to the provider, Foundation Family Chiropractic, within 14 days, of my case settlement. I understand that any settlement, verdict, or judgement cannot be distributed to me without first satisfying this lein.

I clearly understand that the bills which I incur at Foundation Family Chiropractic are my responsibility. I acknowledge that there will be no billing to private or commercial insurance. I agree that if the proceeds from the accident are not enough to satisfy monies owed to Foundation Family Chiropractic that Foundation Family Chiropractic reserves the right to pursue collection of any outstanding balance.

Date: ____________   Patient or Legal Guardian Signature: ________________________

Date: ____________   Staff/Witness Signature: __________________________________

THE UNDERSIGNED ATTORNEY AND HIS/HER FIRM ACKNOWLEDGE THAT HIS/HER CLIENT AGREES TO PAY FOUNDATION FAMILY CHIROPRACTIC DIRECTLY OUT OF THE PROCEEDS FROM THE SETTLEMENT AND NOT AFTER DISTRIBUTION TO THE PATIENT. NEITHER THE ATTORNEY NOR HIS/HER LAW FIRM ASSUMES PERSONAL LIABILITY OF THE MEDICAL BILLS FOR HIS/HER CLIENT.

Date: ___________________ Attorney's Signature: ______________________________

Attorney: Please sign/date and return one copy to this office and retain a copy for your records.

Dr Kyle Heimer, DC
Foundation Family Chiropractic
455-A Old Trolley Road Summerville, SC 29485
843-851-2417 (phone) 843-875-3817 (fax)
EIN: 81-3609472

Insurance Lien/ Assignment of Benefits

Patient's Name: ______________________If Minor, Guardian or Responsible Party: _____________________

Accident Date: __________________

Liability Info
Your Health Insurance Name: ________________________________ Policy #
____
(Please provide this office with a copy of your health insurance card)

OR

Your Auto Insurance Name: _________________________________ Policy #
____
(Please provide this office with a copy of your auto insurance card)

Your Auto Insurance Agent or Adjustor's Name:
____

Your Auto Insurance Agent or Adjustor's Ph # ____

Claim # for this accident: ____

Name of responsible party: _____________________________________ Their ph # ____________________________

Responsible Party's Auto Insurance Name: ___________________________ Policy # _________________________

Their Auto Insurance Agent or Adjustor's Name: ____

Their Auto Insurance Agent or Adjustor's Ph # ____

Claim # for this accident: ____

I, ________________________, do hereby authorize this office to furnish the above listed insurance company, with a full report of my examination, diagnosis, treatments, prognosis etc., in regard to the accident in which I was involved.
I hereby direct the insurance company to withhold the full amount for the billed charges in connection to this accident. I hereby notify the insurance company that I have a lien from the above provider's office in consideration of their willingness to treat me on credit without demand for payment at the time services are rendered. I instruct the insurance company to pay for all services rendered directly to the provider, Foundation Family Chiropractic. I understand that any settlement, verdict, or judgement cannot be distributed to me without first satisfying this lein. I clearly understand that the bills which I incur at Foundation Family Chiropractic are my responsibility.

Date: ____________ Patient or Legal Guardian Signature: ________________________

Date: ____________ Staff/Witness Signature: __________________________________