PERSONAL INJURY QUESTIONNAIRE

NAME: _____ Date of Accident_____

Where did accident happen? Describe the accident in your own words:

What was your position in the car?
□ Driver: if Driver were your hands on the steering wheel? □ Left □ Right □ Both
□ Passenger: If passenger, were you sitting in □ Front □ Right Rear □ Left Rear
Did your vehicle strike another vehicle □ Yes □ No
Was your vehicle struck by another vehicle □ Yes □ No
Angles of impact… First Collision: □ Front □ Back □ Left □ Right
If Second Collision: □ Front □ Back □ Left □ Right
Were you wearing a seat belt? □ Yes □ No
Did you brace for impact? □ Yes □ No … □ I braced with my hands □ I braced 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 chin shoulder Right / Left Knee
□ Steering Wheel _____ □ Dashboard _____
□ Windshield _____ □ Roof_____
□ Left Side Door _____ □ Right Side Door_____
□ Left Side Window _____ □ Right Window _____
□ Other _____
Did the seat back bend / 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 to the hospital? □ Yes □ No if yes 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 Dr. _____
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 a 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

_____
_____

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

☐**Neck pain** check off the areas that the pain runs into from the neck ☐headache ☐Migraine Headache ☐upper back pain	☐none ☐left shoulder ☐left arm ☐left forearm ☐left hand ☐right shoulder ☐right arm ☐right forearm ☐right hand

Ringing in Ears	☐Yes	☐No	☐Left	☐Right	☐Both Ears
Blurry Vision	☐Yes	☐No	☐Left	☐Right	☐Both Eyes
Wrist Pain	☐Yes	☐No	☐Left	☐Right	☐Both Wrists
Jaw Pain	☐Yes	☐No	☐Left	☐Right	☐Both Sides

☐Dizziness ☐nervousness ☐fatigue ☐anxiety ☐depression ☐excessive irritability ☐fear of driving in a car ☐a loss of concentration ☐jaw clenching ☐grinding of teeth at night ☐ nightmares ☐difficulty with sleeping at night

☐**Low Back Pain** select the areas of radiation, if any...	☐none ☐buttocks ☐left buttock ☐left thigh ☐left knee ☐left foot ☐right buttock ☐right thigh ☐right knee ☐right foot

Hip Pain	☐Left	☐Right	☐Bilateral
Knee Pain	☐Left	☐Right	☐Bilateral
Foot Pain	☐Left	☐Right	☐Bilateral

Numbness:

☐ Left Hand	☐Left Upper Arm	☐Right Hand	☐Right Upper Arm
☐ Left Foot	☐Left Leg	☐Right Foot	☐Right Leg

Additional Symptoms/ Complaints:

Have you lost any time from work due to your injuries? ☐Yes ☐No
If yes please give dates: _____
Type of employment:
_____
Have you had previous injuries or accidents? ☐Yes ☐ No
Description of previous Accident: _____
Description of previous injuries: _____
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: _____

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 exam.

- 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. Kinetic Spine & Sports 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's Signature: _____ Date:_____ Front Desk_____ Date:____

Patient Name: _____ DOB: _____ ACCT: _____

Check List for Personal Injury

To accept your personal injury case we need the following:

- ❑ Attorney's name _____
  Phone_____
- ❑ A copy of the Police Report or Exchange Slip
- ❑ Liability Information (Responsible parities 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 SELECTION

_____ I wish to pay my own bill for treatment and be reimbursed by the insurance company.

_____ I wish for Kinetic Spine & Sports 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 sent to him/her.

_____ I choose to have an insurance adjuster to handle my claim and 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 Kinetic Spine & Sports. 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's Signature: _____ Date:_____ Front Desk_____ Date:_____

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 Kinetic Spine & Sports to 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 Kinetic Spine & Sports 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 Kinetic Spine & Sports, 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 Kinetic Spine & Sports for its services rendered.

I appoint Kinetic Spine & Sports 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 I may have with Kinetic Spine & Sports.

I authorize Kinetic Spine & Sports 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 Kinetic Spine & Sports for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If Kinetic Spine & Sports is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Kinetic Spine & Sports for its costs of recovery, including reasonable attorney's fees.

_____
Patient

_____
Date

_____
Witness

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, Kinetic Spine & Sports hereby asserts and gives 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 or settlement of injuries sustained, whether in litigation or otherwise.

Kinetic Spine & Sports 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. Kinetic Spine & Sports agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

Kinetic Spine & Sports

By:_____

Patient Name: _____ DOB: _____ ACCT: _____