PERSONAL INJURY INTAKE

PATIENT INFORMATION

Name ______________________________ **Date** ________________

Address ____

City ____________________ **State** __________ **Zip Code** ________________

DOB __________**Age**________ **Marital Status** __________ Sex ☐ **Male** ☐ **Female**

How did you hear about the office? ______________________________

Home Phone ____________________ **Work Phone** ________________________

Employer ______________________ **Occupation** ________________________

Date of Accident ____________________ **Time of Accident** ______________**AM/PM**

Please Describe the accident in your own words:______________________________

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Were you the: ☐ **Driver** ☐ **Front Passenger** ☐ **Rear Passenger** ☐ **Pedestrian**

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 airbags inflate? ☐ Yes ☐ No

Did your body hit anything inside of the car? ☐ Yes ☐ No

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 car hit anything else? ☐ Yes ☐ No

Did police/ambulance come? ☐ Yes ☐ No

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

Have you missed any days at work since the accident? ◻ Yes ◻ No **If yes, how many?**____________

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

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

Describe condition and treatment:____________________

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Dear Patient,

It is our desire that you have as pleasant an experience in our office as possible. Our most important concern is your health but we do need to do certain things to ensure that your personal injury bills will be taken care of. The following are a list of things all persons involved in an auto accident need to know about.

Please read the following and sign the bottom of this form.

1. *If the car is insured in MA:* YOUR insurance company is responsible for paying your bills, NOT the company of the person who hit you. If the accident was someone else's fault your insurance company will seek compensation from their insurance company. After the first $2,000.00 of total Personal Injury Protection (PIP) benefits are paid out, by law we must bill your health carrier. If your health carrier does not provide chiropractic benefit or if you do not have health insurance your PIP company will continue to pay your bills up to a total of $8,000.00.
2. *If the car is insured in NH*: you have the option of submitting bills to auto insurance, med pay or to your health insurance.
3. It is your responsibility to obtain the following information from your insurance company: Name, Address, Phone, and Fax number, as well as the claim number, name and extension of the PIP adjuster NOT the adjuster for the damage to your car.
4. Your insurance company will send you a form called a "PIP Application". This form must be filled out by you as soon as it is received. Your insurance company will not pay your bills until this form is on file with them. Failure to send in your PIP application will cause the bills to become your responsibility.
5. If you have decided to utilize the help of an attorney you and your attorney will need to sign a Lien form, which is held on file at this office. The Lien is used should you have any outstanding bills that are awaiting settlement to be paid.
6. At some point during your care your insurance company will send you to another doctor for an evaluation. This is called an IME or an Independent Medical Examination. Please inform this office immediately once you are notified of an IME.
7. Keeping your scheduled appointments is imperative, not only for your recovery but also to ensure your claims will be paid. If an insurance company sees you missing appointments or changing your treatment plan without the recommendation of your doctors, they will assume that you are recovered and no longer need care.

I understand the above information and agree to comply fully with the office policies of Parker River Chiropractic & Wellness.

Signed______________________ Date______________ Witness______________________

PERSONAL INJURY INSURANCE INFORMATION

PATIENT NAME ___________________________________ **DATE**_________________

ADDRESS____

PHONE (H) ____________________ (W) ______________________

YOUR AUTO INSURANCE INFORMATION (Or OWNER OF VEHICLE)

NAME OF INSURED____
(IF OTHER THAN YOURSELF)

NAME OF COMPANY____________________________ **CLAIM #** _____________

ADDRESS____

PHONE # _____________________ ADJUSTER _____________ EXT # ____
HAVE YOU HAD OR BEEN SCHEDULED FOR AN INDEPENDENT MEDICAL EXAM (IME)? ________

OTHER DRIVER'S INFORMATION

NAME OF DRIVER ____

NAME OF COMPANY ____

ADDRESS _______________________________________ PHONE _____________

NAME OF ATTORNEY____________________________PHONE___________________

By law in Massachusetts we must bill your personal health carrier after $2,000.00 of personal injury benefits have been exhausted.
PERSONAL HEALTH INSURANCE COMPANY__________________________________
Please provide our receptionist with a copy of your health insurance card.

I HEREBY AUTHORIZE ______________________ INSURANCE COMPANY TO PAY ___________________ DIRECTLY FOR MY HEALTH CARE COSTS. THIS PAYMENT WILL NOT EXCEED MY INDEBTEDNESS TO ________________, AND I AGREE TO PAY ANY BALANCE OF PROFESSIONAL SERVICES OVER AND ABOVE THIS INSURANCE PAYMENT.

I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION PERTINANT TO MY CASE TO ANY INSURANCE COMPANY, ADJUSTER OR ATTORNEY INVOLVED IN MY CASE.

(Please read the above paragraph carefully before signing.)

____ ______________________
SIGNATURE DATE

WITNESS ____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on myself (or on the patient named below for which I am legally responsible) which are recommended by the Doctor(s) of Chiropractic at Parker River Chiropractic & Wellness.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor at Parker River Chiropractic & Wellness and/or with office personnel, the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.
I have read (   ) or have had read to me (   ) the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

____ __________________________

Signature of Patient or Guardian Date

ASSIGNMENT OF INSURANCE BENEFITS

I request payment of insurance and/or Medicare benefits be made on my behalf to Parker River Chiropractic & Wellness. If these payments are made out to me directly, I grant the Parker River Chiropractic & Wellness the full power and authority in my name and stead to endorse any and all checks, drafts of money orders.

I understand all copayments are due at the time of service.

I understand there is no guarantee that my insurance company or pre-paid health plan will cover or pay for all of my charges. I understand that I am financially responsible for any treatment or balances not paid by my insurance company.

____ __________________________

Signature of Patient of Guardian Date

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment, obtain payment from third party payors and conduct normal healthcare operations such as quality assessments and accreditation.

____ __________________________

Signature of Patient of Guardian Date