Mohr Chiropractic Clinic

4031 S. Crestview Dr.

Greencastle, Indiana

(765)653-4447

PERSONAL INJURY QUESTIONNAIRE

Patient Name: _____ Gender: _____
Birth Date: _____
Address: _____
Phone #: _____
Primary Care Physician:_____

Basic Accident Information:

Date accident occurred: _____
Time accident occurred: _____
Describe how the accident took place: _____
_____
_____
_____
Describe your condition of symptoms caused by the accident: _____
_____
_____

Auto Accident Information:

Were you the: _____Driver _____Passenger _____Pedestrian

Automobile you were in: Year_____ Make_____ Model_____

Damage to your car: ___Front ___Rear ___Driver Side ___Passenger Side ___Bumper ___Fender

Damage amount estimate: $_____ Damage type: ___Minor ___Major ___Totaled ___Moderate

Other automobile: Year_____ Make_____ Model_____

Damage to other car: ___Front ___Rear ___Driver Side ___Passenger Side ___Bumper ___Fender

Damage type: ___Minor ___Major ___ Totaled ___ Moderate

Where did the accident happen: Street_____City_____ State_____

Was it? ___Controlled Intersection ___Uncontrolled Intersection ___Not an Intersection

Was there a traffic light? ___None ___Green ___Red ___Turn arrow ___Stop sign

Were you: ___Slowly moving ___Moving ___Stopped

Time of Day: ___Day ___Twilight ___Night

Weather Conditions: ___Clear ___Cloudy ___Rainy ___Sunny

Street Surface: ___Dry ___Wet ___Slick ___Icy ___Pavement ___Other_____

Type of Impact: ___Rear-end ___Front ___Side-impact ___Roll-over

Brakes on Impact: ___Locked Tightly ___Loosely Applied ___Foot not on Brake

Mohr Chiropractic Clinic

4031 S. Crestview Dr.

Greencastle, Indiana

(765)653-4447

How far did your car move? ___Did not move ___Moved 1-5 ft ___Moved 6-10 ft ___ Moved over 10 ft

Where were you seated in the vehicle? _____

Wearing Seat Belt? ___Yes ___No
Shoulder Harness? ___Yes ___No
Headrest? ___Yes ___No
Headrest Position? ___Up ___Down

Is the car equipped with airbags? ___Yes ___No If yes, did they deploy? ___Yes ___No

Did you see the impact coming? ___Yes ___No Did you brace yourself for impact? ___Yes ___No

On impact your head was looking? ___Ahead ___Behind ___Up ___Down ___To the Right ___To the Left

On impact you were? ___Thrown Forward ___Thrown Backwards ___Thrown Sideways ___Other_____

Did your body hit anything inside the car? ___Yes ___No

If yes, what bodypart?_____

If yes, what did it hit?_____

Head Trauma? ___Yes ___No ___ Loss of Consciousness? ___Yes ___No If yes, how long? _____

Do you remember the accident happening? ___Yes ___No

Did you go to the hospital? ___Yes ___No Hospital Name?_____ How long?_____

Taken by ambulance? ___Yes ___No

X-rays taken? ___Yes ___No If yes, X-ray areas? ___Neck ___Mid Back ___Low Back ___Other_____

Medication Given? ___Yes ___No If yes, what kind?_____

Other instruction?_____ Follow Up?_____

Additional Information Related to Condition

Describe your pain: __Burning __Sharp __Dull __Ache

What caused it?_____

What aggravates it?_____

What relieves it?_____

Have you ever experienced the same condition before? __Yes __No If yes, when? _____

Please describe: _____

Mohr Chiropractic Clinic

4031 S. Crestview Dr.

Greencastle, Indiana

(765)653-4447

Have you seen any other healthcare providers for your accident condition? __Yes __No

If yes, Name_____, Type of Doctor_____, Date of last visit_____

Please check any of the following symptoms you are now experiencing:

__Headache	__Dizziness	__Light bothers eyes	__Diarrhea
__Loss of memory	__Clumsiness	__Feet cold	__Neck stiff
__Hands cold	__Sleeping problems	__Tingling in legs/feet	__Face flushed
__Numbness arms/hands	__Buzzing in ears	__Constipation	__Nervousness
__Cold sweats	__Tension	__Shortness of breath	__Fainting
__Irritability	__Loss of smell	__Chest pain/rib pain	__Pain in arms/hands
__Loss of strength(arms)	__Burning muscle pain	__Loss of strength (legs)	__Difficulty swallowing
__Head seems too heavy	__Neck pain	__Tingling in arms/hands	__Ears ringing
__Nausea	__Back pain	__Numbness legs/feet	__Loss of balance
__Fever	__Fatigue	__Pain in legs/feet	__Jaw pain
__Sharp/shooting pain	__Other_____		

Have you experienced changes to:

__Eyes (sight)	__ Ears (hearing)	__ Nose (smell)	__ Mouth (taste)	__Bladder
__Bowels	__ Sleep	__Emotions	__Appetite	

__Other (please explain)_____
Please explain changes:_____

Have you missed work or school as a result of your injuries? __Yes __No
Do you smoke? __Yes __No If yes, how many packs per day? _____
Do you drink alcohol? __Yes __No If yes, how many drinks per day? _____

Past Medical History

Have you been in our office before? __Yes __No
List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc) and provide the accident date:
1) _____
2) _____

List any previous surgeries and/or hospitalizations:
1) _____
2) _____

Allergies (please list all): _____
_____

List all medications you are taking now and why: _____
_____

Do you now or have you ever had?

__ Heart Disease	__Diabetes	__Cancer	__Stroke
__High Blood Pressure	__Thyroid Problem	__Tuberculosis	__Prostate Disorder
__Kidney Problems	__Asthma	__Ulcer	__Seizure Disorder

__Other _____

Mohr Chiropractic Clinic

4031 S. Crestview Dr.

Greencastle, Indiana

(765)653-4447

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Anderson Chiropractic P.C., I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

PATIENT ACKNOWLEDGEMENT OF NON-COVERED SERVICES

Under your health care plan, you are financially responsible for copayments, coinsurance, or deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. This may include, but is not limited to, Vitamins & Supplements, Supports, Strapping, and Maintenance Care. Your signature below indicates that you have been advised of this information and that you agree to pay for any non-covered services according to your insurance contract.

Patient/Guardian Signature:_____ Date:_____

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I understand that parents or guardians are responsible for all fees and services rendered for treatment for myself and/or child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing claims with my insurance company does not relieve me from my responsibility for the payment of all charges.

_____ _____

Signature of Patient, Parent, or Guardian Date

_____ _____

Printed name of Patient, Parent, or Guardian Relationship to Patient

TIME OF SERVICE DISCOUNT AGREEMENT

Our office offers all patients a Time of Service discount. This discount is 15% off of our standard fees. The TOS discount does not include nutritional supplements, supports, orthotics, or hair analysis. In order to qualify for this discount, you must agree to the following:

- All services must be paid at the time the service is rendered.
- Your claim will not be submitted to insurance. We will provide you with a receipt and you can submit it to your insurance company if you so choose.
- If you choose to take the TOS discount, it will apply to ALL services rendered.
- Your choice regarding the TOS discount will remain in effect until you sign another TOS form stating your intentions to change.

_____ I choose to take the TOS discount. I understand that Anderson Chiropractic will not bill my insurance company.

_____I choose not to take the TOS discount. I understand that Anderson Chiropractic will bill my insurance company and I will be responsible for any outstanding amounts applicable after my insurance company processes my claim.

Mohr Chiropractic Clinic

4031 S. Crestview Dr.

Greencastle, Indiana

(765)653-4447

Patient Acknowledgement and receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name _____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy at their request of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is also available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Dated this _____ day of _____ , 20_____

By _____
Patient's Signature

If patient is a minor or under guardianship order as defined by State law:

By _____
Signature of Parent or Guardian

Mohr Chiropractic Clinic

4031 S. Crestview Dr.

Greencastle, Indiana

(765)653-4447

Personal Injury Patient Financial Agreement

(Initial One)

_____ **OPTION 1:** I will pay Mohr Chiropractic for my services as they are rendered to me, and it will be my responsibility to supply receipts and receive reimbursement from my car insurance, the other persons' car insurance, or any attorney/law firm involved.

_____ **OPTION 2:** I will supply all of my personal MEDPAY insurance information including the name of my car insurance company, the claim number, contact person, address and phone number, and financial benefits and/or limits to such benefits. Mohr Chiropractic will submit my medical claims to my med pay insurance in order that my insurance company can reimburse Mohr Chiropractic as I am being treated. ***(If I pick Option 2, I will also read and sign the Authorization to bill MEDPAY form).***

- ***My Auto Insurance Company:_____***
- ***Claim #: _____***
- ***Agent/Adjuster Name: _____***
- ***Phone Number: _____***

Signed:_____

Date:_____

Staff Signature:_____

Mohr Chiropractic Clinic

4031 S. Crestview Dr.

Greencastle, Indiana

(765)653-4447

Authorization to Bill MEDPAY

I _____ (print name) do hereby give full permission and authorize Mohr Chiropractic P.C. to bill my MEDPAY for services rendered to me. I also agree that if possible, to have any checks from such services payable and deliverable to:

Mohr Chiropractic P.C.
7390 Business Center Drive
Avon, IN 46123

By signing this document I also agree to the following statements below:

I understand that MEDPAY is a separate medical benefit rider attached to my automobile insurance. This covers my health care bills when I am involved in an automobile accident that has caused health-related problems for which I will receive treatment. I also understand that there are generally monetary limits to how much will be paid from such rider.

I understand that MEDPAY is NOT my health insurance. I also understand that any monies received via a 3rd party insurance carrier (i.e. Other driver's auto insurance carrier) are separate from MEDPAY monies.

For the purpose of this injury, I understand that Mohr Chiropractic P.C. is utilizing my MEDPAY policy, NOT my health insurance as the primary source of payment for services rendered to me.

I understand that I am responsible for obtaining information about my MEDPAY policy and providing such information to Mohr Chiropractic P.C. for correct billing. Such information includes *claim number, name of company, billing address, billing phone number, contact person and financial benefits and/or limits to such benefits.* **I also understand that if I hire an attorney to represent this accident, I will notify the office manager immediately at Mohr Chiropractic and provide information including law firm, attorney, address, and phone number.**

I understand that Mohr Chiropractic P.C. will be providing services and billing my MEDPAY for those services at various times during the course of my chiropractic treatment. I also understand and give permission for Mohr Chiropractic P.C. to bill my MEDPAY before my health insurance for the payment of care and services rendered to me.

I understand that ultimately I am responsible for all payment relating to any and all charges relating to treatment and services that I have received at Mohr Chiropractic P.C.'s office during my care. If my claim settles and payment is sent to me directly, I will promptly (within 5 business days) pay Mohr Chiropractic any outstanding balance that is still owed.

The undersigned does agree to observe and abide by all of the statements made above.

_____ _____
Patient or Guardian Signature Date

_____ _____
Staff Signature Date