PERSONAL INJURY QUESTIONNAIRE

NAME: _____ DATE OF ACCIDENT: _____

Where did accident happen? Please describe the accident in your own words:

What was your position in the car?
____ Driver: Where were your hands on the steering wheel? Left ___ Right ___ Both ___
____ Passenger: Where were you sitting? Front ___ Right Rear ___ Left Rear ___ Center Rear ___
Did your vehicle strike another vehicle? Yes ___ No ___
Was your vehicle struck by another vehicle? Yes ___ No ___
Angles of impact: 1st Collision: Front ___ Back ___ Left ___ Right ___
2nd Collision: Front ___ Back ___ Left ___ Right ___
Were you wearing a seat belt? Yes ___ No ___
Did you brace for impact? Yes ___ No ___ If yes: Braced with my hands ___ 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, shoulder, knee, & right or left):
Steering Wheel _____Dashboard _____
Windshield _____Roof _____
Left Side Door _____Right Side Door _____
Left Side Window _____Right Side Window _____
Other _____
Did the seat belt bend or 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? Yes ___ No ___ If yes, for 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 Doctor: _____
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 an 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 / Info: _____

Patient Name:_____ DOB:_____ ACCT:_____

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

Neck Pain? Yes ___ No ___
If yes, check off the areas that the pain runs from the neck:
Left Shoulder ___ Left Arm ___ Left Forearm ___ Left Hand ___ Headaches ___
Right Shoulder ___ Right Arm ___ Right Forearm ___ Right Hand ___ Upper Back ___

Ringing in Ears? Yes ___ No ___ if yes: Left ____ Right ____ Both ____
Blurred Vision? Yes ___ No ___ if yes: Left ____ Right ____ Both ____
Wrist Pain? Yes ___ No ___ if yes: Left ____ Right ____ Both ____
Jaw Pain? Yes ___ No ___ if yes: Left ____ Right ____ Both ____

Low Back Pain? Yes ___ No ___
If yes, check off the areas that the pain radiates to:
Both Buttocks ___ Left Buttock ___ Left Thigh ___ Left Knee ___ Left Foot ___
Right Buttock ___ Right Thigh ___ Right Knee ___ Right Foot ___

Hip Pain? Yes ___ No ___ if yes: Left ____ Right ____ Both ____
Knee Pain? Yes ___ No ___ if yes: Left ____ Right ____ Both ____
Foot Pain? Yes ___ No ___ if yes: Left ____ Right ____ Both ____

Numbness?
Hands? Yes ___ No ___ if yes: Left ____ Right ____ Both ____
Upper Arms? Yes ___ No ___ if yes: Left ____ Right ____ Both ____
Legs? Yes ___ No ___ if yes: Left ____ Right ____ Both ____
Feet? Yes ___ No ___ if yes: Left ____ Right ____ Both ____

Other:
Dizziness___ Nervousness___ Fatigue___ Anxiety___ Depression___ Excessive Irritability___
Fear of Driving___ Loss of Concentration___ Jaw Clenching___ Grinding Teeth___ Nightmares ___
Difficulty sleeping___

Additional Symptoms / Complaints:
_____
_____
_____
_____
_____
_____

Have you lost any time from work due to your injuries? Yes ___ No ___
If yes, please provide dates: _____
Type of employment? _____
Have you had previous injuries or accidents? Yes ___ No ___
If yes, please describe previous injuries: _____
Please describe previous accidents: _____
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.): _____

Check List for Personal Injury

To accept your personal injury case we need all of the following:

____ Attorney's Name_____
Attorney's Phone_____

____ A copy of the Police Report or Exchange Slip

____ Liability Information (Responsible Parties 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 Section

____ I wish to use my personal health insurance and pay my own bill for treatment.

- I understand I am responsible for paying my copayment, deductible and/or coinsurance amount at the time services are rendered.
- I also understand if my health insurance denies claims for any reason that I will be responsible for balance due.

____ I wish for Crossroads Family Chiropractic 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 send to him/her.
____ I choose to have an insurance adjuster to handle my claim and have 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 Crossroads Family Chiropractic. 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 Signature:_____ Date:_____ Front Desk:_____

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 Crossroads Family Chiropractic 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 Crossroads Family Chiropractic 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 Crossroads Family Chiropractic, 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 Crossroads Family Chiropractic for its services rendered.

I appoint Crossroads Family 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 a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance may have with Crossroads Family Chiropractic.

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

_____
Patient

_____
Date

_____
Witness

NOTICE OF LIEN

Pursuant to N.C.G.D. 44-49 and 44-50, Crossroads Family Chiropractic hereby asserts and give 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 settlement of injuries sustained, whether in litigation or otherwise.

Crossroads Family Chiropractic 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. Crossroads Family Chiropractic agrees to be bound by any confidentially agreements regarding the contents of the accounting.

CROSSROADS FAMILY CHIROPRACTIC

By:_____

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.

- 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. Crossroads Family Chiropractic 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 Signature:_____ Date:_____ Front Desk:_____ Date:_____

CROSSROADS FAMILY CHIROPRACTIC
DR. RYAN L WILLIAMS
58 OLD ROBERTS RD BENSON, NC 27504
PHONE: (919)-989-1888 • FAX: (919)-989-1898

Patient Name:_____ DOB:_____ ACCT:_____