

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:

<input type="checkbox"/> Neck pain check off the areas that the pain runs into from the neck	<input type="checkbox"/> none	<input type="checkbox"/> left shoulder	<input type="checkbox"/> left arm	<input type="checkbox"/> left forearm	<input type="checkbox"/> left hand
	<input type="checkbox"/> right shoulder	<input type="checkbox"/> right arm	<input type="checkbox"/> right forearm	<input type="checkbox"/> right hand	
<input type="checkbox"/> headache					
<input type="checkbox"/> Migraine Headache					
<input type="checkbox"/> upper back pain					

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

<input type="checkbox"/> Low Back Pain select the areas of radiation, if any...	<input type="checkbox"/> none	<input type="checkbox"/> buttocks	<input type="checkbox"/> left buttock	<input type="checkbox"/> left thigh	<input type="checkbox"/> left knee
	<input type="checkbox"/> left foot	<input type="checkbox"/> right buttock	<input type="checkbox"/> right thigh	<input type="checkbox"/> right knee	<input type="checkbox"/> right foot

Hip Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Bilateral
Knee Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Bilateral
Foot Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> 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 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 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: _____