Allied Healthcare, PLLC

Patient Information

Motor Vehicle/Personal Injury Questionnaire

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Birthday: _____ Sex: _____ Social Security Number: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Emergency Contact: _____ Phone: _____

Marital Status: (Circle) Single Married Widowed Divorced

Who referred you to our office? How did you hear about us? _____

Are you pregnant? (Circle) YES NO (If so, Congrats!!) Due Date: _____

Who is your primary care physician? _____

WHO IS RESPONSIBLE FOR THE BILL

Responsible Party Name: _____ Responsible Party Birthday: _____

Personal Health Insurance Company: _____

(Please provide us a copy of your personal insurance card if you want us to put it on file)

Auto Insurance Company: _____ Claim #: _____

Adjuster Name: _____ Phone Number: _____

Auto Insurance Company: _____ Claim #: _____

Adjuster Name: _____ Phone Number: _____

Current Condition:

Date of Collision: _____ Time: _____ AM/PM

Where did the Collision Occur? City/State: _____

Please Describe Below How the collision occurred:

_____
_____
_____
_____
_____
_____
_____

Where you the: (Circle) DRIVER PASSENGER PEDESTRIAN

If you were the passenger, were you in the: (Circle) Front Seat Right Rear Left Rear Middle

What type of Vehicle were you in: _____

What type was the other Vehicle: _____

Did your Vehicle strike the other Vehicle: (Circle) YES NO

Was your car struck by the other Vehicle: (Circle) YES NO

Were you surprised by the impact: (Circle) YES NO

Were you braced for the impact: (Circle) YES NO

Was the impact from: (Circle) FRONT REAR LEFT SIDE RIGHT SIDE

What was the approximate speed at the time of impact: _____

Your Vehicle: _____MPH Other Vehicle: _____MPH

What was the weather like at the time of the collision? (Circle) DRY WET ICY SNOWY

Was your vehicle in: (Circle) PARK NEUTRAL IN GEAR MOVING STOPPED

Were your brakes being applied: (Circle) YES NO

Did the seat you were in have a headrest: (Circle) YES NO

If yes, What was the position: (Circle) LOW MID-POSITION HIGH

Did your head ride over the headrest: (Circle) YES NO

Were the airbags deployed: (Circle) YES NO

Did any part of your body hit the interior of the Vehicle: (Circle) YES NO

Please specify: (Circle) SEATBELT RESTRAINTS STEERING WHEEL DASHBOARD WINDSHIELD

SIDE DOOR SIDE WINDOW OTHER: _____

Which part of your body: (Circle) CHEST HEAD CHIN FACE R L KNEE R L SHOULDER

R L HAND OTHER_____

Did you brace your arms: (Circle) YES NO

Did the Vehicle go into a spin or roll as a result of the impact: (Circle) YES NO

Please explain: _____

How much damage was there to the interior of the Vehicle: (Circle) NONE SOME A LOT

How much damage was there to the exterior of the Vehicle: (Circle) NONE SOME A LOT

At the point of impact, where did you experience pain? Please be specific:

_____

Immediately following the accident, were you: (Circle) Conscious Dazed Unconscious

If you lost Consciousness, how long was it for: _____

Were you wearing your seatbelt: (Circle) YES NO

At the time of impact, were you: (Circle) Looking Straight Ahead Looking to the Right

Looking to the Left Looking Down Looking Up

Did you go to the Hospital: (Circle) YES NO

If yes, when: (Circle) Right after the accident Other

If by Ambulance, did the EMT place you in a: (Circle) NECK BRACE BACK BRACE
OTHER:_____

Were there any medications given: (Circle) YES NO If so, what:_____

If you went to the Hospital, please answer the following:

Name of the Hospital: _____

Treating Physician: _____

Diagnosis: _____

Treatment Received: _____

Have you had similar problems before: (Circle) YES NO

What type of work do you do: _____

What are your job requirements: _____

Have you lost any days of work from this injury: (Circle) YES NO

If yes, please list dates: _____

List all Medications along with dosage if known. If there are no medications check here: _____

1._____ 2._____

3._____ 4. _____

5._____ 6. _____

List any known allergies you have to any medications. If no allergies check here: _____

1._____ 2. _____

3. _____ 4. _____

List any Surgical Operations and years:

1._____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

In the space below, please describe any additional information you believe we need to know about your case, including all medical conditions or information not already included in this packet:

_____
_____
_____
_____
_____
_____

Please list any social, recreational, household, or work activities that are now more difficult or impossible to do because of your current problems:

_____
_____
_____
_____

On the diagram below, please indicate where you feel the following sensations. Use the appropriate symbol and please include all areas of the body that have been affected.

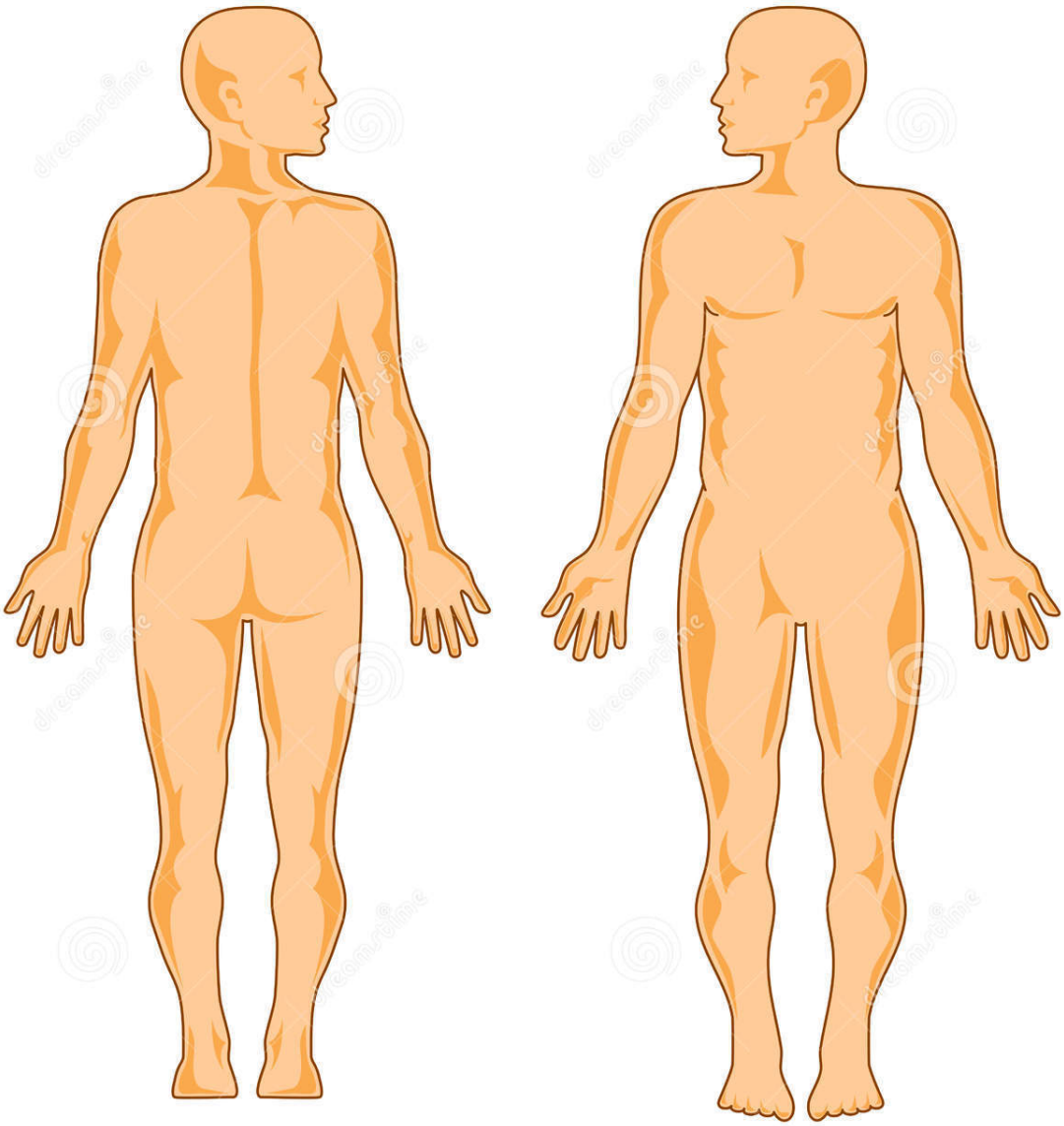
Aching Pain ******

Burning Pain XXXXXX

Numbness ======

Pins and Needles oooooo

Stabbing Pain //////



	What bothers you most?	Next most?	Next most?
	_____ _____ _____	_____ _____ _____	_____ _____ _____
When did this problem begin?			
This problem began: (Circle)	Gradually Suddenly	Gradually Suddenly	Gradually Suddenly
This problem can be best described as: (Circle)	Sharp Stabbing Dull Tingling Burning Aching Throbbing Other:_____ _____	Sharp Stabbing Dull Tingling Burning Aching Throbbing Other:_____ _____	Sharp Stabbing Dull Tingling Burning Aching Throbbing Other:_____ _____
This problem is: (Circle)	Constant Near Constant Frequent Rarely Present Other:_____ _____	Constant Near Constant Frequent Rarely Present Other:_____ _____	Constant Near Constant Frequent Rarely Present Other:_____ _____
This problem is worse with:			
This problem is better with:			

Signature: Date:

_____ _____

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgements based upon facts and information known to the doctor. The doctor uses this judgement based upon facts and information known to the doctor. The doctor uses this judgement to attempt to anticipate or explain the risks and complications and an undesirable result does not necessarily indicate an error in judgement. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course treatment based upon facts known that is in my best interest.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and sprain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that the best of my knowledge, I am not pregnant, nor is this pregnancy suspected or confirmed at this time. Date of last menstrual cycle:_____

Patient Name (printed): _____

Patient Signature:_____

Relationship or authority if not signed by Patient:_____

Witness:_____ Date:_____

Doctor's Lien

I do hereby authorize, Allied Healthcare/Dr. Aaron Nelson/Dr. Jeff Haskell/Dr. Stewart Curtis/Dr Scott Treat, to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself with regard to the accident which I was involved in on (date):_____.

I hereby authorize and direct you, my attorney, to pay directly to the said doctor(s) such sums as may be due and owing him for medical service(s) rendered me by reason of the above accident and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor(s). I hereby further give a lien on my case to said doctor(s) against any and all proceeds of me settlement, judgement or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or in connection herewith.

I agree to never rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney will honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him or her.

I fully understand that I am directly and fully responsible to the said doctor(s) for all medical bills submitted by him for service(s) rendered me and that this agreement is made solely for the said doctor(s) additional protection and in consideration of his waiting payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not wait for payment but declare the entire balance due and payable.

Patient Name_____ Date_____

Patient Signature_____ Date_____

Acknowledgement of Attorney

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms above and agrees to withhold such sums from the settlement, judgement or verdict as may be necessary to adequately protest said doctor(s) above named. Any settlement of this claim without honoring this assignment/lien will cause you to be responsible to this office for payment. The prevailing party in any litigation resulting from enforcement of this lien shall be entitled to actual attorney's fees and court costs.

Attorney Name_____ Date_____

Attorney Signature_____ Date_____

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If you do not have insurance: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $300 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.**
2. **If you have insurance: All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance must not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.**

You are considered a cash patient until you bring in your complete insurance information, and we will qualify and accept your insurance coverage.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept the responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment. You further agree to pay as a collection fee of 33% of the principal amount to reimburse Allied Healthcare its collection costs if my account is assigned to a collection agency.

Personal Injury Cases: If an account balance is not paid in FULL within six (6) months of the first date of service, the patient will be required to begin making minimum monthly payments toward the account balance regardless of settlement/claim status.

If you discontinue care for any reason other than discharge by the doctoral balances will become immediately due and payable in full by you, regardless of any claim submitted.

We bill insurance carriers as a courtesy to our patients, it is not required by law for us to do so. It is ultimately the patients responsibility to contact your insurance carrier to determine what services may or may not be covered. It is also your responsibility to contact your insurance company regarding any questions of payment and/or denials of treatment.

Date:_____

Patients Printed Name:_____

Patient Signature or Legal Guardian:_____

ACKNOWLEGDEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received or asked for a copy of Allied Healthcare, PLLC's notice of Privacy Practices for protected health information.

Date:_____

Name of Patient (printed):_____

Signature of Patient/Personal Representative:_____