VEHICLE ACCIDENT INFORMATION

Patient Name: _____ Today's Date: _____/_____/_____
Date of accident: _____/_____/_____ Time of Accident _____ ☐ a.m. ☐p.m.
Please describe the accident in your own words: _____
_____
_____
Were you the: ☐Driver ☐Front Passenger ☐Rear Passenger ☐Pedestrian
How many people were in the accident vehicle? _____
What is the name of all involved insurance companies? _____
What is the adjuster's name handling your case: _____ Phone: _____
Claim number assigned to your case: _____ Policy number: _____

ACCIDENT SITE

Road/Street Name: _____
City/State: _____
Nearest intersection with road/street:_____
Driving conditions: ☐Dry ☐Wet ☐Icy ☐Other: _____
Which direction were you headed?_____
Speed you were traveling? _____

VEHICLE

Make and model of vehicle you were in:
_____
Were you wearing a seatbelt? ☐Yes ☐No
If yes, what type? ☐Lap ☐Shoulder
Was vehicle equipped with airbags? ☐Yes ☐No
If yes, did they inflate properly? ☐Yes ☐No
Did your seat have a headrest? ☐Yes ☐No
If yes, what was the position of the headrest?
☐Low ☐Mid-position ☐High
How much property damage was done to vehicle?
_____

OTHER VEHICLE

Make/model of other vehicle: _____
Direction other vehicle was headed: _____
Speed other vehicle was traveling: _____
How much property damage was done to other vehicle? _____

IMPACT

Did your car impact another vehicle? ☐Yes ☐No
Did your car impact a structure? ☐Yes ☐No
If yes, explain: _____
_____
Did any part of your body strike anything in the vehicle?
☐Yes ☐No If yes, explain: _____
Was impact from: ☐Front ☐Rear ☐Left ☐Right
☐other _____
At the time of the impact were you:
☐Looking straight ahead ☐Looking to the right
☐Looking to the left ☐Looking down
☐Looking up
Were both hands on the steering wheel: ☐Yes ☐No
If no, which hand was on the wheel? ☐Rt ☐ Left
Was your foot on the brake? ☐Yes ☐No
If yes, which foot was on the brake? ☐Rt ☐Left
Were you: ☐Surprised by impact ☐Braced for impact

POLICE

Did the police come to the accident site? ☐Yes ☐No
Were there any witnesses? ☐Yes ☐No
Was a police report filed? ☐Yes ☐No
If yes, do you have a copy of report? ☐Yes ☐No
Was a traffic violation issued? ☐Yes ☐No
If yes, to whom and explain: _____
_____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐Yes ☐No If yes, for how long? _____
Please describe how you felt immediately after the accident: _____
_____

TREATMENT

Did you go to the hospital ☐Yes ☐NO When? ☐Immediately after accident ☐Next Day ☐2 or more days after
How did you get to the hospital? ☐Ambulance ☐Private Transportation
Name of Hospital:_____ Name of Doctor: _____
Diagnosis: _____
Treatment received: _____ X-rays taken: ☐Yes ☐No

SYMPTOMS/INJURIES

Did this injury arise from an automobile accident? ☐Yes ☐No

Have you been able to work since this injury? ☐Yes ☐No How many days have you missed? _____

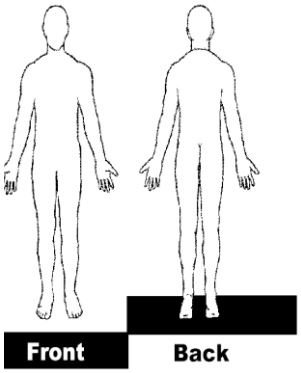
Prior to the injury were you able to work on an equal basis with others your age? ☐Yes ☐No

Please check any and all of the following symptoms you have had since your injury:

☐ **Arm/Shoulder Pain**	☐ **Feet/toe numbness**	☐ **Neck pain**
☐**Back pain**	☐ **Hand/Finger numbness**	☐ **Neck stiff**
☐ **Back stiff**	☐ **Headaches**	☐ **Shortness of breath**
☐ **Chest pain**	☐ **Irritability**	☐ **Sleep difficulty**
☐ **Dizziness**	☐**Jaw problems**	☐ **Stomach upset**
☐ **Ear Buzzing**	☐**Leg Pain**	☐ **Tension**
☐ **Ear Ringing**	☐ **Memory Loss**	☐ **Vision Blurred**
☐ **Fatigue**	☐ **Nausea**	

Is this condition getting progressively worse? ☐ Yes ☐No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling:



Rate the severity of the pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain:

☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting
☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐ Swelling ☐ Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ☐Work ☐Sleep ☐ Daily Routine ☐Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐Standing
☐ Walking ☐Bending ☐ Lying down

I certify that the above information is correct to the best of my knowledge.

I authorize any insurance company that is in any way involved with any aspect of my claim to disclose any and all aspects of my claim to my doctor so that appropriate status may be determined in the processing of my claim.

_____ _____

Patient Signature **Date**

Instructions: Within each section, please indicate how your current symptoms are affecting your daily living by selecting one of the options.

Self Care/Hygiene

[__] I can provide for myself on most of my personal care.
[__] I can provide for myself, but it creates extra pain.
[__] I can provide for myself, I am slow, careful, and it is painful.
[__] I manage most of my personal care, but it requires some help.
[__] In most accommodations of my daily care, I require extra help.
[__] It is to difficult to care for myself, I stay in bed and do not perform these tasks.

Communication

[__] I can communicate in a normal fashion.
[__] I can communicate, but it causes some pain.
[__] My communication abilities are normal, but always painful.
[__] My communication abilities are restricted by pain.
[__] Pain seriously limits my communication except for emergencies.
[__] Pain prevents communication abilities completely.

Normal Living - Sitting

[__] I am able to assume a sitting position for an indefinite period of time without pain.
[__] I can sit down for an indefinite period of time, but it causes some pain.
[__] I am restricted to one hour of sitting due to pain.
[__] Due to pain, I am only able to sit for 30 minutes.
[__] Pain restricts sitting for longer than 10 minutes.
[__] I am unable to sit due to pain.

Normal Living - Standing

[__] I am able to stand as long as I like without pain.
[__] I am able to stand for an indefinite period of time, but it causes pain.
[__] I am restricted to one hour of standing due to pain.
[__] Due to pain, I am only able to stand for 30 minutes.
[__] Pain restricts standing for longer than 10 minutes.
[__] I am unable to stand due to pain.

Normal Living - Lifting

[__] I am able to lift heavy objects without pain.
[__] I am able to lift heavy objects, but it causes some pain.
[__] I am unable to lift heavy objects off the floor. However, I can manage if they are at table height.
[__] Due to pain, I am not able to lift heavy objects. However, light to medium weight objects are manageable.
[__] Pain restricts lifting only very lightweight objects.
[__] I am unable to lift any objects of any weight at all.

Ambulation

[__] I am able to walk any distance without pain restrictions.
[__] I am limited to walk one mile due to pain restrictions.
[__] I am limited to ½ mile of walking due to pain.
[__] Due to pain, I am restricted to walking less than ¼ mile.
[__] I require the use of crutches or a cane to assist walking.
[__] I remain in bed most of the time due to pain.

Travel

[__] I am able to travel without pain restrictions.
[__] I am able to travel almost anywhere, but it causes pain.
[__] I can manage 2 hours of travel, but pain is present and severe.
[__] Due to pain, I am limited to less than an hour of travel time.
[__] Only short, urgent trips are possible due to pain limitations.
[__] I am restricted in travel due to pain, other than emergencies of short distances (hospital, doctor visits).

Non Specialized Hand Activities

[__] I can grasp in a normal fashion.
[__] I can utilize grip and tactile discrimination, but there is some pain.
[__] My grasp and grip capabilities are normal, but always painful.
[__] Grasping, grip strength can tactile sensations are restricted by pain.
[__] prevents grip strength, grasping and tactile discrimination completely.
[__] Pain prevents grip strength, grasping and tactile discrimination completely.

Sexual Function

[__] I am able to engage in normal sexual activities without pain.
[__] I am able to participate sexually, but it creates some pain.
[__] I engage normally in sexual activities, but it is very painful.
[__] I am restricted in sexual activities due to pain.
[__] Pain has created a near absent sex life.
[__] Due to pain, I abstain from any sexual activities.

Sleep

[__] I sleep well in a normal fashion.
[__] I sleep well at night, as long as I use sleeping pills.
[__] I fail to accomplish more than 6 hours of sleep.
[__] I fail to accomplish more than 4 hours of sleep.
[__] I fail to accomplish more than 2 hours of sleep.
[__] Pain prevents sleep.

Social & Recreational Activities

[__] I am enjoying a normal, active social life without pain restrictions.
[__] The presence of pain affects only the more energetic activities of my social life (bowling, golfing, sports, etc.).
[__] I participate in a normal social life, but pain is increased during most activities.
[__] Pain restricts all of my social activities; therefore, I do not go as often.
[__] I am restricted to social activities at home due to pain.
[__] Due to pain, I do not participate in any social activities.

The Effects Of Medication

[__] I am able to tolerate pain; therefore, I do not use any pain medication.
[__] I use pain medication and experience complete relief from pain.
[__] I use pain medication and experience moderate relief from pain.
[__] Pain medication offers only very little relief from pain.
[__] Pain medication fails to offer relief; therefore, I no longer take them. ** IF taking medications please indicate which ones and dosage: _____
_____

Any Allergic reactions to medications: _____
_____

Pain Intensity

[__] My pain is MINIMAL and tolerated, it is annoying, but does not limit my physical performance.
[__] Pain is SLIGHT and tolerated; it causes some limitations on my physical performance.
[__] I experience MODERATE pain, which causes a significant limitation on my physical performance of activities.
[__] I experience SEVERE pain, which reduces my capability to perform any activity.

Pain Frequency

[__] I have INTERMITTENT symptoms occurring less than 25% of my wake time.
[__] I experience OCCASIONAL symptoms between 25% and 50% of my wake time.
[__] Pain is FREQUENT, and occurs between 50% and 75% of my wake time.
[__] I have CONSTANT pain occurring between 75% and 100% of my wake time.

Assignment and Authorization

(To be signed by both the patient and attorney/insurance adjuster)

You are hereby authorized to disclose and/or furnish my attorney(s) and/or auto-insurance company with any and all medical information, bills, and/or records in your possession which they request in reference to any illnesses and injuries which I have suffered.

I further, irrevocable assign to you, and authorize and direct said attorneys/insurance adjusters to pay from the proceeds of any recovery in my case all reasonable fees for result of the injury or condition heretofore mentioned. I understand that this in no way relieves me of my personal primary obligation to pay for such services and that the signing of this form does not prohibit customary billing by you. All bills shall be paid promptly in the usual manner. This specifically includes but is not limited to any and all Pip, Med-pay, or Med-expense payments.

It is further understood that there is a Statute of Limitations applicable to any civil claim you may bring. In view of this, I hereby agree that the Statute of Limitations with respect to any claim for services mentioned above will not begin until I send you a denial, in writing, of any outstanding balance. Said written denial must be mailed certified mail, return receipt requested, and said return receipt will be required to show proof of the notice of this denial.

_____

Patient Name

_____ _____

Patient Signature Today's Date

Claim Number: _____ Date of Injury: _____

Witness: _____ Date: _____

The undersigned attorney/adjuster for the patient referred to above hereby agrees to comply fully with the foregoing "Authorization and Assignment" and agrees to advise the named assignee in writing the status of the claim of the patient within ten days of the request, and agrees to notify the assignee if the attorney/adjuster ceases to represent this patient and/or if the claims is dropped or denied.

_____ _____

Attorney or Insurance Adjuster Signature Date

Personal Injury Insurance Form:

Date of Accident: _____ Insurance Company: _____
Patient Name: _____ Insured Name: _____
Adjuster Name:_____ Phone: _____Ext: ____
Fax: _____

Claims Address:_____

Policy #: _____ Claim #: _____

Notes:
_____
_____

CREDIT GUARANTEE
AUTO INSURANCE ASSIGNMENT
PERSONAL BALANCES

INSURANCE ASSIGNMENT

Our Auto Insurance Assignment Program is designed to render you immediate care and keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your insurance carrier on your behalf and wait up to 3 months for payment. Please remember, however, that you are ultimately responsible for payment. As a prerequisite, we ask that you provide a credit card to guarantee payment of your bill and that you provide us with the following:

Your complete automobile insurance information
Your family health insurance plan information

FILING PROCEDURE

We will submit claims on your behalf to 3rd party payers periodically and at the conclusion of your care.

Any overpayments resulting in credit balances will be refunded promptly at the conclusion of your care.

Balances not paid within 3 months after conclusion of your care will be charged to your designated credit card below. You will be sent a payment voucher. Should settlement be reached prior to the 3 month grace period or should care be terminated for any reason prior to your physician dismissal all balances become due immediately and will be charged to your credit card and are subject to monthly interest charges.

CREDIT CARD: ❒ VISA ❒ MC

CARDHOLDER NAME _____

CARD # _____ EXP. DATE _____
CREDIT CARD BILLING ADDRESS: _____
CVV NUMBER: _____ (LAST 3 DIGUTS AT THE BACK OF YOUR CARD)
I agree to the above terms and authorize you to bill the charge card. I understand that should payment not be received within 3 months after termination of my care or should I terminate care before being dismissed by your physician, I will be charged the amount outstanding on my account.
Signature _____ Date _____

Waiver of Health Insurance Benefits

I, _____, the undersigned, do hereby waive health insurance responsibility for all treatment and care arising from my injury, which occurred on _____ (date of injury). I am not filing for health insurance benefits or Medicare and waive their responsibility for one or more of the following reasons:

1. I have not followed my insurance plan's procedure to obtain a referral from my primary care physician to seek services by a participating specialist.
2. I am seeking care from a non-participating health care provider whose care may require the payment of a higher out of pocket co-pay and deductible from me, or whose care may not be covered by my health insurance.
3. Because of the nature of my injuries and/or legal case, I have chosen not to use my health insurance benefits or Medicare to cover any of the health care received as a result of this injury.
4. The law does not require health care providers to do many of the things that can help prosecute my liability claim. For example, the law does not require doctors to take attorney telephone calls, to meet with the lawyer prior to depositions, or to provide records and reports not otherwise required by law. These and many other courtesies, which can help my case, take valuable billable time away from the doctor. I am asking the doctor, of my own free will, to extend these types of courtesies. I understand the doctor may charge for these extra matters. In return, I am agreeing to waive my health benefits, as outlined below. This health care provider may act in complete reliance upon my waiver, in taking actions that it would otherwise not take. The significant benefits I receive from this agreement constitute the consideration necessary to enforce this agreement. These are my wishes.

I agree and understand that I am accepting responsibility to pay for any services rendered herein. I am instructing my health care provider not to file any claims for benefits with my health insurance plan for treatment relating to or arising from the injuries I sustained in this accident. This decision is being made freely and voluntarily by me, without interference or pressure from others, and is made with the understanding of the responsibilities, which arise there from.

_____ _____

Patient Signature Date

_____

Patient Name