Chiropractic Health
Matthews • Dilworth

Personal Injury Checklist and Packet

Name:_____

MED PAY

- Company name: _____
- Address: _____
- Phone: _____
- Medical Adjustor Name: _____
- Claim # _____
- Med Pay Amount Available _____

(ATTACH COPY OF CARD)

Health Insurance Company

- Company name: _____
- Address: _____
- Phone: _____
- Medical Adjustor Name: _____
- Policy Number #_____ Group# _____

(ATTACH COPY OF CARD)

Attorney

- Company name: _____
- Address: _____
- Phone: _____
- Attorney Name: _____
- Email Address: _____
- Paralegal Contact: _____

Party at Fault's Information

- Company name: _____
- Address: _____
- Phone: _____
- Medical Adjustor Name: _____
- Claim # _____

NOTE: This checklist assists us in verifying what is available to you in the way of financial support for your care. Failure to provide accurate information will affect our ability to communicate with the carriers correctly. This information is required prior to the beginning of care. Failure to provide ALL information will result in your care being rescheduled.

Acknowledged: _____ Date: _____

Clinic Representative: _____
Date:_____

Accident/Injury Questionnaire

Name: (Last, First MI)_____Today's Date:_____

Automobile Accident - Additional Information

- Was anyone else in the vehicle with you? ⬜ No ⬜ Yes - Number of People _____
- You were (check a box and circle all that applies)?
  - ⬜ Front Seat - Driver / Passenger
  - ⬜ Rear Seat - Behind driver / Middle / Behind Passenger / 2nd row / 3rd row
- Name of Driver (if not self) _____
- Name of Driver of other Vehicle _____
- Did airbags deploy? ⬜ No ⬜ Yes
- Did Police Arrive? ⬜ No ⬜ Yes
- Using a Seat belt? ⬜ No ⬜ Yes
- Did you strike the windshield or object in the car? ⬜ No ⬜ Yes - Describe _____
  _____
- Were you knocked unconscious? ⬜ No ⬜ Yes - How long? _____
- Where was your vehicle impacted (circle all that apply)? Front / Rear / Passenger Side / Driver's Side / Other: _____
- Where was the other vehicle impacted (circle all that apply)? Front / Rear / Passenger Side / Driver's Side / Other: _____
- Your Auto Ins: _____ Policy #_____ Claim #_____Phone #_____
  Address_____City_____State:_____Zip:_____
- Other's Auto Ins: _____Policy #_____ Claim #_____Phone #_____
  Address_____City_____State:_____Zip:_____

General Accident / Injury Information

Date of Accident: _____ Time: _____ (AM / PM)
Please describe the accident in as much detail as possible. _____
_____
_____
_____
_____
_____

Before the accident / injury:

- Have you ever had any complaints in the involved area before? ⬜ No ⬜ Yes
  - If yes - Were they present at the time of the accident / injury? ⬜ No ⬜ Yes
    - If yes - How?_____Where?_____
- Were you capable of performing all of your work activities with restriction? ⬜ No ⬜ Yes

At the time of the accident / injury:

- Did you feel pain immediately after the accident? ⬜ No ⬜ Yes ⬜ Later that day ⬜ Next day ⬜ When? _____
- Were you taken anywhere after the accident? ⬜ No ⬜ Yes ⬜ Later that day ⬜ Next day ⬜ When? _____
  - If yes - How?_____Where?_____
  - If yes - Did you receive treatment? ⬜ No ⬜ Yes - (describe)_____

Since the accident / injury:

- Are your symptoms: ⬜ Improving? ⬜ Getting Worse? ⬜The Same?
- Are your work activities restricted as a result of this accident/injury? ⬜No ⬜ Yes - (how?) _____
- Have you missed any work since the accident? ⬜ No ⬜ Yes - (dates?) _____
- Have you retained an attorney? ⬜ No ⬜ Yes - Name_____
  Phone #:_____Address:_____
  City:_____State:_____Zip:_____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____

Relationship to patient: _____

Authorization for the Release of Medical Records

Patient Name _____Date of Birth:_____
(also list maiden name/other names used)

I hereby request and authorize:
Chiropractic Health of Matthews
434 N. Trade St. Ste. 103
Matthews, NC 28105

Tel: 704-845-0777
Fax: 704-845-0778

_____**To Disclose Information to:** _____ **To Receive Information from:**

Name/Provider:_____

Address:_____

City/State/Zip_____

Phone:_____ Fax:_____

Information to be disclosed include copies of:

_____ Entire Record
_____ Progress Notes
_____ Physical Exam Forms
_____ Daily Chart Notes
_____ X-ray Reports
_____ X -ray Films
_____ MRI / Reports
_____ Other, specify: _____

Purpose of Disclosure:

_____ Treatment, Payment
_____ Other (specify) _____

This authorization will be effective for six months after the date signed, unless canceled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

_____ Date:_____
Signature of Patient

_____ Date:_____
Signature of Legal Representative/Relationship

If signing for a minor patient, I hereby state that my parental rights have not been revoked by court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosure of this information without the specific written consent of the patient or legal representative.

Chiropractic Health of Matthews: 434 N. Trade Street Suite 103, Matthews, NC 28105

Chiropractic Health of Dilworth: 1710 Kenilworth Ave, Ste. 190, Charlotte, NC 28203

Election Not to File Health Insurance Claims
(Personal Injury/Accident)

The chiropractor(s) at this clinic are participating ("in-network") providers for your health benefit plan. As participating providers, we are obligated to file claims for reimbursement with your plan for all covered services provided to you UNLESS you instruct us in writing not to file.

You have indicated that for services related to this personal injury, rather than using your own health insurance, you wish to consider seeking payment from other third-party payors such as the at-fault driver's liability insurance. To help you make an informed decision, please carefully review the following information.

If you elect NOT to file claims on your health insurance:

1. The clinic will rely on your decision and extend credit to you for the cost of care based on the assumption that your bill will be paid by sources other than your health insurance. **You will be required to assign to the clinic the right to receive monies paid by liability insurers, medical payments insurers or other third-party payors to the extent necessary to satisfy your bill.**

2. You will not be required to pay co-payments/co-insurance and/or deductibles that would normally be required by your health benefit plan.

3. The cost of your treatment will be billed at the clinic's usual rates rather than the discounted rates that routinely apply to services covered by your health benefit plan.

4. If the combined payments received from other sources do not fully satisfy your bill, you may be personally liable for any unpaid balance.

5. None of the charges for your treatment will be applied towards satisfying the annual deductible (if applicable) associated with your health benefit plan.

If you elect TO file claims on your health insurance:

1. Your health insurance should pay the cost of *covered* services associated with this accident/injury EXCEPT FOR copayments, co-insurance and/or deductibles, which you will be expected to pay directly to the clinic at the time services are rendered.

2. You will be responsible for paying to the clinic the cost of any *non-covered* services you elect to receive, and your payment will be due at the time services are rendered.

3. If your health benefit plan initially pays the clinic for your treatment and later determines that it is not legally responsible for payment, the plan administrator may require the clinic to refund to the plan all or part of the payments received. If that happens, you will become responsible for reimbursing the clinic the amount it was required to refund.

4. Your health benefit plan requires the clinic to submit claims in a timely fashion and while timely filing requirements vary, most plans require claims to be filed within 3-6 months from date of service. If your action or inaction causes a claim to be submitted late, the claim could be denied, and you would be responsible for paying this clinic for those services which were denied.

Election not to file health insurance claims:

1. By my signature below, I attest that I have read and understand the above information regarding the options available to me and have been given an opportunity to ask questions and to have those questions answered.
2. I hereby instruct the clinic not to file claims on my health insurance for services associated with this accident/injury, and I authorize the clinic to seek payment from, and send my treatment records to, other third-party payors who are potential sources of payment.

3. I understand that the clinic is relying on my decision not to file health insurance claims, and that with regards to claims related to this accident/injury, this decision is irrevocable.

4. I understand that no subsequent action on my part shall impair the clinic's right to bill and receive payments from third-party payors; subject only to any contractual obligation the clinic may have to my health benefit plan.

_____	_____
Printed Name of Patient	**Printed** Clinic Representative
_____	_____
Signature of Patient (or parent/legal guardian, as applicable)	Signature of Clinic Representative
_____	_____
Date:	Date:

A complete copy of this executed agreement must be maintained in the patient's health care record, and a copy must be provided to the patient.