The Balanced Body Center
10550 Independence Pointe Parkway
Suite 100
Matthews NC 28105
704/ 849-9393
Fax 704/ 845-8589

Automobile Accident Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractor can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank You.

Name: _____ Sex: _____ DOB: _____
Social Security #: _____ Driver's License #: _____
Home Phone: _____ Work Phone: _____
Spouse's Name: _____ Spouse's Employer: _____
Address: _____
City: _____ State: ____ Zip: _____ Employer: _____

Who referred you to our office? _____

What **DATE** did the injury occur? _____

Please explain how your accident happened: _____
_____

Have you retained an attorney? ☐Yes ☐No
If YES, please provide your attorney's information:
Attorney's Name and Company: _____
Address: _____
Telephone: _____

Did you require post accident hospitalization? ☐Yes ☐No
Which hospital? _____
Name of treating doctor? _____
What treatment was given? _____
If NOT, where were you taken after the accident? _____

Please check **all** symptoms you have noticed **since** the accident?

☐Headache	☐Dizziness	☐Depression	☐Fatigue
☐Stomach upset	☐Light bothers eyes	☐Buzzing in ears	☐Diarrhea
☐Neck pain	☐Head seems heavy	☐Loss of memory	☐Feet cold
☐Neck stiffness	☐Pins and Needles	☐Ears ringing	☐Hands cold
☐Fainting	☐Sleeping problems	☐Loss of balance	☐Back pain
☐Face flushed	☐Constipation	☐Tension	☐Nervousness
☐Numbness if fingers	☐Loss of smell	☐Fever	☐Irritability
☐Numbness in toes	☐Loss of taste	☐Chest pain	☐Cold sweats
☐Shortness of breath	☐Other: _____		

Did the police come to the accident? ☐Yes ☐No
Do you have a copy of the report? ☐Yes ☐No If YES, please provide us a copy.
How much property damage was done to your car? $_____

Are your work activities restricted as a result of this accident? ☐Yes ☐No
If YES, please explain what daily activities/hobbies have been restricted:

_____

Please provide us with the names, contact information, and claim numbers of all involved insurance companies:

YOUR insurance information:		**OTHER PARTY's** insurance information:	
Insurance Co:		Insurance Co:	
Address:		Address:	
Telephone:		Telephone:	
Contact Name:		Contact Name:	
Claim #:		Claim #:	

Disclosures & Agreement

Please select ONE of the following options:

☐ Refusal to Waive Heath Insurance Benefits

I have instructed *The Balanced Body Center* to file the bill for my injuries sustained in my auto accident, which occurred on the date listed above, to my Health Insurance Company or Medicare. If for some reason my health insurance company denies payment, I agree to abide by *The Balanced Body Center's* Financial Policy, which includes paying for all care at the time of service. As a reminder, HIPAA Privacy Rules (as detailed in our *Notice of Privacy Practices*) permit the disclosure of your medical records for payment purposes.

If I select this option, *The Balanced Body Center* has made it clear that it is ready and willing to submit this claim to my Health Insurance Company or Medicare.

☐ Waiver of Health Insurance Benefits

I do hereby waive my health responsibility for all treatment and care arising from my injury, which occurred on the date listed above. I am not filing for health insurance benefits or Medicare benefits and waive their responsibility. These are my wishes.

If I select this option I understand it is my responsibility to provide a properly executed *Assignment and Authorization* (signed by my attorney and myself). Without a properly executed *Assignment and Authorization*, I agree to abide *The Balanced Body Center's* Financial Policy, which includes paying for all care at the time of service.

I understand that ALL health insurance companies and Medicare contractually impose limits on the time *The Balanced Body Center* has to file a claim. I understand that if my case is ultimately unsuccessful, and my health insurance company's maximum filing limit has lapsed, my outstanding balance for services rendered will be paid in full according to *The Balanced Body Center's* Financial Policy. I understand that *The Balanced Body Center* WILL NOT file claims to my health insurance company under the above mentioned circumstances.

I agree and understand that I am accepting responsibility to pay for any services rendered herein. I am instructing *The Balanced Body Center* NOT to file any claims for benefits with my health insurance plan or Medicare for treatment relating to or arising from injuries sustained in this accident. This decision is being made freely and voluntarily by me, without interference or pressure from others.

I understand and agree that *The Balanced Body Center* will prepare any necessary reports and forms to assist me in settlement of the accident. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be IMMEDIATELY due and payable.

Patient Signature: _____ Date: _____
Witness: _____ Date: _____

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I hereby authorize and direct you, the insurance company and/or attorney, to pay directly to **The Balanced Body Center** such sums as may be due and owing this office for services rendered me, both by reason of accident of illness, and by reason of any other bills that are due this office, and withhold such sums from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, Workmen's Compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office. I hereby further give a lien to said office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

In the event of my insurance company to make payments to me upon the charges made by this office for their services refuses to make such payments, upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in this office's name and further I authorize this office to compromise, or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for this total amounts due the office for their services. I further understand and agree that this Assignment, Lien, and Authorization does not constitute any consideration for the office to await payments and they may demand payments from me immediately upon rendering services at their options.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien and Authorization. Payment for services rendered should be mailed directly to the office of **The Balanced Body Center**.

I further understand and agree that if this office must take action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this office for all costs of such collection efforts, including but not limited to all court cost and attorney fees.

Patient Name (print) _____

Signature _____ Date _____

Witness _____ Date _____

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As of January 2002, our office policy agreement with personal injury cases will be the following:

We **will not accept** any third party billing through insurance companies.

It will be your responsibility for full payment as services are rendered to you in our office. We will, however, provide you with the correct information in aid of receiving reimbursement. This includes any office notes, x-rays performed, and/or payments received by you.

Our office will accept assignment for services rendered by the doctors in this office, if and only you have retained an attorney authorized by our facility. We will require a Letter of Representation from your attorney within 10 business days. If we do not receive this information, you will take on full responsibility for any services performed for your healthcare in this facility.

I understand and agree with the above statements.

_____