Auto Injury Information

Name ____ Today's Date ____________________________
Date of Accident ____ Time of Accident___________ AM PM
Location of Accident
____
Type of Accident: [ ] Auto/Traffic [ ] Work/On Job [ ] At Home [ ] Other
____
Describe how the accident happened in your own words:
____
____
____
____
____
Name of Hospital: ______________________________________ Attended by Dr.____________________

Were you x-rayed at the hospital? [ ] Yes [ ] No
If so, what was the diagnosis? ____

Were you admitted to the hospital? [ ] Yes [ ] No
How long did you stay? ____
What treatment was rendered?____
What recommendations were made?
____
List any other doctors you have seen as a result of this accident:
____
____

Have you lost any time from work because of this accident? [ ] Yes [ ] No
If yes, give days of disability: ____________________________
Totally disabled from ________________ to ______________
Partially disabled from ______________ to ________________
Have you returned to work since the accident? [ ] Yes [ ] No

Were you wearing a seat belt? [ ] Yes [ ] No

What kind of vehicle hit yours? __________________________________
What kind of vehicle were you in? _______________________________

If auto accident, were you the [ ] Driver [ ] Passenger [ ] Pedestrian?
If passenger, were you sitting in the [ ] Front [ ] Right Rear [ ] Left Rear? [ ] Other _______________
Did your vehicle hit other vehicle(s)? [ ] Yes [ ] No

Estimated speed of your vehicle at impact? ____________ MPH
Was your vehicle hit by another vehicle(s)? [ ] Yes [ ] No
Estimated speed of other vehicle at impact? ___________ MPH

Did your car strike the other(s) involved? [ ] Yes [ ] No
or did the other car strike yours? [ ] Yes [ ] No [ ] Undetermined

VEHICLE YOU WERE IN:	OTHER VEHICLE
Driver ____________________	Driver: ____________________
Insured: ____________________	Insured: ____________________
Address: ____________________	Address: ____________________
Phone: ____________________	Phone: ____________________
Auto Insurance Co.: ____________________	Auto Insurance Co.: ____________________
Ins. Co. Address: ____________________	Ins. Co. Address: ____________________
Adjuster: ____________________	Adjuster: ____________________
Phone: ____________________	Phone: ____________________
Policy #: ____________________	Policy #: ____________________
Claim # ____________________	Claim # ____________________

Did you require post-accident hospitalization? [ ] Yes [ ] No

CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

[ ] Headache
[ ] Neck pain
[ ] Neck stiff
[ ] Sleeping problems
[ ] Back pain
[ ] Nervousness
[ ] Tension
[ ] Irritability
[ ] Chest pain
[ ] Dizziness
[ ] Head seems too heavy
[ ] Pins & needles in Arms
[ ] Pins & needles in Legs
[ ] Numbness in toes
[ ] Shortness of breath
[ ] Fatigue
[ ] Depression
[ ] Light bothers eyes
[ ] Loss of memory
[ ] Face flushed
[ ] Buzzing in ears
[ ] Loss of balance
[ ] Fainting spells
[ ] Loss of smell
[ ] Loss of taste
[ ] Diarrhea
[ ] Numbness in fingers
[ ] Feet cold
[ ] Hands cold
[ ] Stomach upset
[ ] Constipation
[ ] Cold sweats
[ ] Fever
[ ] Ears ring
[ ] Other ____________________

Symptoms other than above: ____

____

Have you lost days of work? [ ] YES [ ] NO Dates: ____________________

Name of your Insurance Company involved: ____________________________

____

Name of person at your Insurance Company responsible for injuries: ____________________

____

Have you been contacted by an Insurance Adjuster/Company Representative regarding this claim? [ ] YES [ ] NO

Do you have an attorney who has advised you in this case? [ ] YES [ ] NO

Name: ____

Address of Attorney: ____________________________ Phone No: ____________________

Patient's Signature: ____________________________ Date: ____________________

INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete ALL questions. If you need help please ask the receptionist. PLEASE PRINT.

Today's Date _______________

Name __________________________________ Home Phone ______________ Work Phone _______________

Address _________________________________ City __________________ State _________ Zip ___________

Age _____ Birth date __________________ Marital Status: S M W D Number of Children ______

How did you hear about our office? ____________________________________

Please circle one payment type: Cash Check Master Card/Visa

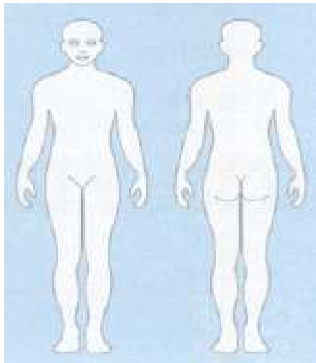
Your Employer _____________________________ Occupation _____________________ Years On Job ____

Do you have Medicare? Yes ____ No ____ Do you have Medicaid? Yes ____ No ____

Name of Spouse or Parent ___________________________________ Their Birth date ________________

Spouse Employed By ___________________________ Occupation _________________ Years On Job ____

Does your spouse have health insurance at work? Yes _____ No _____



COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram.

What is your main complaint? ____

____

What event, if known, brought about this problem? _________________________

____

How long have you suffered with this problem? _____________________________

Is the pain: Sharp? ______ Dull? ______ Throbbing? ______ Constant? ______ Intermittent? ______

What activities make your condition/pain worse? ____

What activities give you some temporary relief? ____

What have you tried that DID NOT work? ____

Is your condition interfering with work? _____ Sleep? ____ Family? ____ Routine? ____ Other? _________

Please explain: ____

On a scale of 1-10 (1=minor, 10=worst possible), please rate:

The severity of your symptoms: 1 2 3 4 5 6 7 8 9 10

Any other complaints? ____

____

____

Please list any drugs or medications you are currently taking: _____________________________________

____

Do you have a family history of Heart Disease? ____ Cancer? ____ Diabetes? ____ Other? _____________

Have you had or do you currently suffer from any of the following:

□ Headaches/Migraines	□ Pins & Needles in Legs	□ Depression	□ Reflux
□ Neck Pain	□ Frequent Colds/Infections	□ Ears Ringing	□ Diarrhea
□ Sleeping Problems	□ Pins & Needles in Legs	□ Light Bothers Eyes	□ Fatigue
□ Back Pain	□ Pins & Needles in Arms	□ Digestive Difficulties	□ Infertility
□ Irritability	□ Numbness in Toes	□ Chest Pains	□ Allergies
□ Numbness in Fingers	□ Menstrual Problems/Pain	□ Breathing Difficulties	□ Stiff Neck

Type of Insurance: ___ Worker's Comp. ___ Health Insurance ___ Automobile Insurance ___ None

Is your condition due to an accident? Yes ______ No ______ Date of accident? ___________________

Type of accident? Auto ______ Work/On Job ______ At Home ______ Other __________________

Have you been in an auto accident? Past Year _____ Past 5 Years _____ Over 5 Years _____ Never _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered will be immediately due and payable.

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Insurance cases: On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.

In the event that my account becomes 60 days past due and I have not responded to monthly statements, I understand that my account will be turned over to a local collection agency. I agree to pay any and all fees charged by the collection agency.

I (we) authorize Dr. Montgomery to perform diagnostic x-rays if needed in this case so that a complete analysis can be made of the present musculoskeletal problem (or illness) and to diagnose or administer whatever treatment is deemed necessary.

Patient's Signature ____ Date _________________________

Or Guardian Signature ____ Date _________________________

FOR LADIES

To the best of my knowledge, I am NOT pregnant and the above named Doctor has my permission to perform x-rays if needed for diagnostic interpretation.

Patient's Signature ____ Date _________________________

Terms of Acceptance

When a person seeks Chiropractic care and we accept a person for such care it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent confusion.

Adjustment: A specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. Our focus in this office is the vertebral subluxation. However, if we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnoses or treatment for those findings we recommend that you seek another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to locate, analyze and correct vertebral subluxation by specific adjustments.

I, ________________________________ have read and fully understand the above statements.
(Print name)

All questions regarding the chiropractor's objective to my care in his office have been answered to my complete satisfaction. I therefore accept care on this basis.

Signature: _______________________________________ Date: _______________________________

Consent to evaluate and adjust a minor child

I, ________________________________ being the parent or legal guardian of ____________________________
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care. If you agree sign below.

Signature: _______________________________________ Date: _______________________________

OFFICE FINANCIAL POLICY

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.

2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

INSURANCE

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.

2. We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment per visit.

3. We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.

4. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check – it will not come from your insurance company. All insurance payments, regardless of which company issues a check, first, are applied to your account as long as any balance is due.

5. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.

6. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.

7. If the patient is referred to another specialist of discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full immediately; regardless of any claims submitted. If patient has a credit on his or her account, refunds are processed at the beginning of the next month and are dependant on insurance reimbursement if applicable. Any refund given from a credit card payment will be charged a 3% processing fee.

8. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.

9. I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process Insurance claims by provider or agent. I designate this provider, practice and Agent as Authorized Representative with Durable Power of Attorney in insurance related matters. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

10. I hereby authorize and direct my insurer to issue payment for services rendered by Montgomery Chiropractic Wellness Center, LLC. Regardless of my benefit, I understand that I am financially responsible for the fees for services rendered, that finance charges may accrue on past due balances, and that failure to pay will result in the account being turned over to an outside collection agency. I agree to pay all attorney fees and court costs incurred in collecting any unpaid balances for services rendered.

Thank you.

I have read and understand the Financial Office Policy and agree to abide by these terms.

______________________________ ____________________

Patient’s Signature Date

AUTHORIZATION, ASSIGNMENT & RELEASE FORM

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care from me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges you incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you, based in whole or in part upon the charges made for your services.
3. In the event any insurance company is obligated, by contractual agreement, to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you. I herby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and take action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance companies' proceeds, whether it is all or part of what is due, I personally owe and agree to pay to you.
4. In addition to the above, I herby waive the statute of limitations on collection and/or recovery in this State of Indiana.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization and Assignment will be in continual effort until revoked by both parties.

________________________________ ___________

Patient/Insured Signature Date

RECORDS RELEASE

To ____________________________, I herby authorize you to release to ______________________ any information including the diagnosis and records of treatment or examination rendered to me or all care during the period from _______________ to _________________.

_____________ ____________________ _____________ __________________________

Date Patient/Insured Signature Date Staff Signature

RELEASE FROM CARE

I, ________________________________ hereby understand that Dr. _________________ is releasing me from care, for my accident dated _______________, and that I have reached [ ] pre-accident status or [ ] maximum medical improvement. I further understand that all expenses incurred from this accident are my responsibility or the insurance company's and that all expenses incurred after the date below will be my personal responsibility. I will make financial arrangements for payment directly.

Parent Signature ______________________ Date_______________ Staff Signature ________________________

Office Use F/C : ❑ INS ❑ MC ❑ MD ❑ IO ❑ WC ❑ AA ❑ PI ❑ SP MC # _______________

Included : ❑ Insurance Card Copy ❑ Employer Claim Form ❑ Referral / Script

PATIENT INFORMATION

Thank you for choosing Montgomery Chiropractic. In order to help us complete records and submit accurate bills to your insurance company, please assist us by providing the following information :

Today's Date : ______________________________ Patient's Soc. Sec. # : ____________________________________

First Name : ______________________________ M.I. : _______ Last Name : _________________________________

Mailing Address : ____

Zip Code : _______________________ City : _____________________________________ State : _______________

Home # : (_______)________________ Work : (_______)________________ Cell : (_______)_________________

Date of Birth : _________________________________ ❑ Male ❑ Female

Employer : ____ Occupation : ____________________________

Referred By : ❑ Self ❑ Friend ❑ Insurance Carrier ❑ Primary Physician ❑ Other _________________________

INSURANCE PATIENTS

Please complete the following section and present your Insurance Cards.

	PRIMARY INSURANCE	SECONDARY INSURANCE
Relation to Insured:	❑ Self ❑ Spouse ❑ Child ❑ Other	❑ Self ❑ Spouse ❑ Child ❑ Other
Complete the following Insured information if *RELATION* is other than *SELF*.		
Insured's Name:		
Insured's Birthdate:		
Insured's Insurance ID:		
Male or Female:		
Employer:		
Complete the following Insured information if it differs from the Patient's.		
Insured's Address:		
City, State, Zip:		
Phone Number:	( )	( )

ACCIDENT PATIENTS

CLAIM FILING INFORMATION	
WORK COMP OR MEDPAY INFORMATION	*ATTORNEY INFORMATION*
Date of Injury:	☐ Attorney Only - no WC or Medpay Info
Insurance Carrier Name:	Name :
Carrier Address:	Address :
City, State, Zip:	City, State, Zip :
Adjuster's Name:	Contact :
Adjuster's Phone : ( )	Phone : ( )
Claim Number:	File No. :

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my Insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process Insurance claims by provider or agent. I designate this provider, practice, and agent as Authorized Representative with Durable Power of Attorney in insurance related matters. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

Patient Signature : ____ Date : ____________________________