If you have been in a car accident

Why We Usually Do Not File With Health Insurance:

We may request information concerning your personal health insurance policy although we do not file for our services using this policy unless there is no auto insurance coverage or litigation settlement. Health insurance policies typically have deductibles, co-payments, restricted timely filing dates, and treatment and fee guidelines that may not be within our usual and customary established treatment and fee protocols, and therefore not paid in full by your policy which will ultimately be your responsibility.

Please Sign Our Other Forms:

It is our office policy to protect payment for our services and request that you initial and/ or sign a number of forms protecting them and allowing us to file directly and be paid directly from any insurance carriers and if applicable an attorney. We apologize for any inconvenience this may pose but it has been our experience that clarity is best at the beginning of care and your financial obligations known. If you have any questions or concerns, please have them answered prior to your initialing or signing any forms.

Collection Policy:

We will utilize the services of a collection attorney if our fees are not paid by you or any insurance carrier or attorney. This is especially true if not paid directly after your settlement with either of them. Collection and attorney fees of 35-50% above your balance and accrued interest of the total outstanding balance will be your responsibility and may affect your credit history.

I have read the above and understand my responsibilities:

Printed Name: ____

Signature: ____

Witnessed and Notarized: ____

Date: _______________________

ATTENTION ACCIDENT PATIENTS

If you are in an accident or incur a personal injury and would like us to file it with your insurance company these are the steps that we must follow.

- **First,** we will bill the injured parties Med-Pay (which is primary)

  * What is Med-Pay and do you have it? Also known as automobile medical payments coverage. You may have paid for it and don't know that you have it so check with you automobile insurance company to see if you selected to have this option. When this option is selected your auto insurance company should pay for any medical expenses up to your limits selected as a results of injuries sustained in or around an automobile. **MED-PAY COVERS YOU REGARDLESS OF FAULT AND DOES NOT AUTOMATICALLY CAUSE AN INCREASE IN YOUR INSURANCE RATES WHEN USED.** The only requirement is that the chiropractic and/or medical bills be "responsible" and the treatment be "necessary"!

- **Secondary,** we will file with the injured parties Group Medical Insurance carrier.
- **Third,** we will file with at fault insurance company, upon settlement of claim with medical lien.
- **Fourth,** file with uninsured motorist coverage, if there is no at fault party insurance party insurance to purse. (Possibly seek legal advice)
- **Fifth,** the injured party pays. (Self pay unless you have sought legal counsel)

Patients Name: ____

Signature: ____

Date: ___________________________

DR. RON REDMAN
CHIROPRACTIC

Personal Injury Auto Accident Forms

Today's Date____________________

Name ____ Address ____

City ________________________State _____Zip ____________ SS#____

E-Mail Address____ Cell Ph#____________________________

Work #____________________________ Home Ph#________________________________

DOB ____/____/______ AGE _____ Sex: ☐ Male ☐ Female

Occupation: _____________________________________ Employer: ____

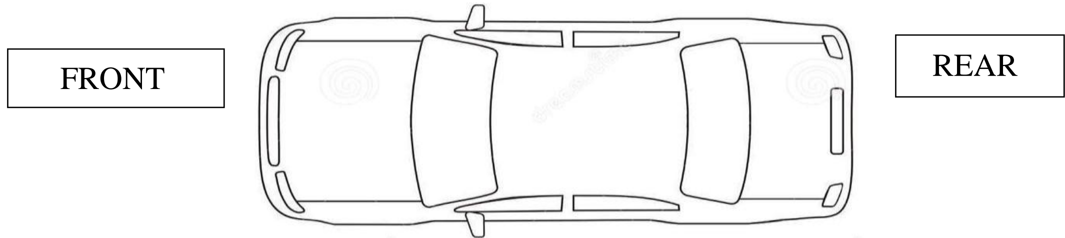
Date of Accident_____/_______/________ Time of Accident:______________________ AM/PM

Describe your accident in detail ____

____

____

Where was your vehicle struck?



Type of Accident: ☐ Rear impact (hit from behind) ☐ Head-on collision ☐ Broad-side collision ☐ Front Impact

☐ Rear-ended car in front ☐ Non-collision

Were you stopped?_________________ Were you looking straight ahead or to the side?______________________

You were going?_______________mph. They were going?________________mph. Wearing seat belts? ☐ Yes ☐ No

Were you the driver or the passenger?_______________________ Sitting in front or rear?______________________

Year & Model of your car_____________________________________ Type of their car___________________________

Were you gripping the steering wheel tightly? ☐ Yes ☐ No Foot hard upon the brakes? ☐ Yes ☐ No

Were you aware the collision was to take place? ☐ Yes ☐ No Unconscious? ☐ Yes ☐ No

What was the approximate damage done to your car?_________________________________

<u>After the Accident</u>:

Did you feel tight in the: arms, chest, or neck (circle)

Did you feel your neck move: backwards, forwards, and/ or sideways (circle)

Did you feel your upper and lower body move: forwards, backwards, or sideways (circle)

Did any part of your body make contact with the car, where? ____

____

Were you bruised, where ____

Did you seek medical help immediately after the accident? ☐ Yes ☐ No

If yes, how did you get there? ☐ Ambulance ☐ Police ☐ Someone else drove me ☐ Drove my own car

☐ Other:____

Which Hospital ____ Were X-rays taken ☐ Yes ☐ No

Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars

If yes, what kind of treatment did you receive? ____

Were you able to drive home? _________ Go to work? ☐ Yes ☐ No How long after accident______________________

Have you taken time off from work? ☐ Yes ☐ No If yes, how many days ________________

Describe your normal work routine ____

Have you seen any additional Doctors for your injuries? ☐ Yes ☐ No Date started:____________ Ended:____________

Their names and specialty ____

What was done ____ Were X-rays taken? ☐ Yes ☐ No

Have they helped _____________________________________Have you been released from care___________________

How has it affected your activity at work: ____

____

At home: ____

____

Social activities (sports/ type: ____

List any previous surgery history: ____

List any implants or prosthesis: ____

Please list any or all previous accident history: ____

How did you feel immediately after the accident?
Notate #1 to #10 (10 being the worse)

Neck__________ Shoulder__________ Headaches__________ Nervous __________ Dizzy _________ Mid Back__________

Abdomen__________ Chest __________ Vision __________ Jaw__________ Low Back __________ Hips __________

Arms __________ Legs __________ Numbness __________

As of Today How Do You Feel?
Notate #1 to #10 (10 being the worse)

Neck__________ Shoulder__________ Headaches__________ Nervous __________ Dizzy _________ Mid Back__________

Abdomen__________ Chest __________Vision __________ Jaw__________ Low Back __________ Hips __________

Arms __________ Legs __________ Numbness____________

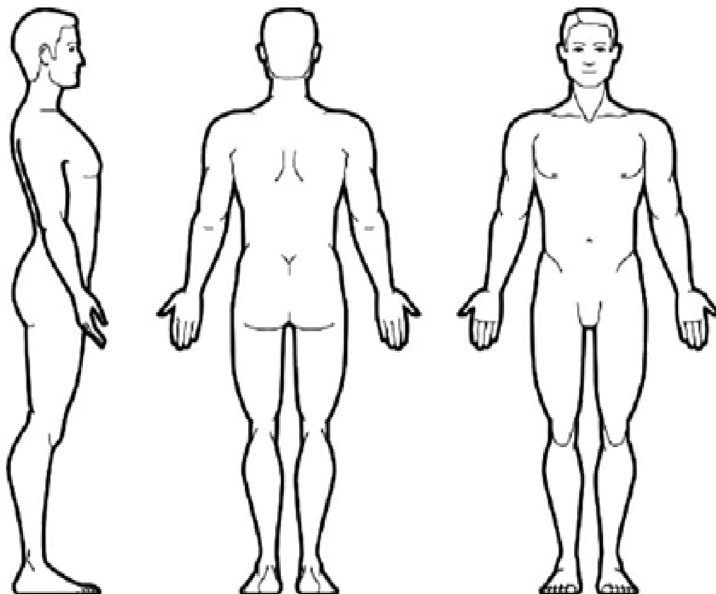
Current Chief Complaint (s): Please check ☐ all appropriate complaint areas.

SPINE
☐ Neck ☐ Mid Back ☐ Low Back ☐ Pelvis

UPPER EXTREMITY
☐ Shoulder R/L ☐ Wrist R/L ☐ Arm R/L ☐ Forearm R/L ☐ Elbow R/L ☐ Hand R/L

LOWER EXTREMITY
☐ Hip R/L ☐ Leg R/L ☐ Thigh R/L ☐ Ankle R/L ☐ Knee R/L ☐ Foot R/L

Mark the areas on your body where you feel the described sensations. Mark stress points where the pain radiates. Include all your affected areas.



Use the appropriate symbols listed below to indicate areas of pain.

P (PAIN)

N (NUMBNESS)

R (RADIATING)

B (BURNING

S (STABBING)

PN (PIN & NEEDLES)

Is your present symptoms the direct result of the accident you described above? ☐ Yes ☐ No

Do you already have an attorney on this claim? ☐ Yes ☐ No

If yes, who? ____

Address ____

City__________________________ State_____________ Zip____________

Phone (   )__________________________

Note: Payments for all services to REDMAN CHIROPRACTIC are your responsibility. If you intend on using any form of insurance with or without an assignment of benefits, or pay partially for your care received while being treated here, use health insurance with lower negotiated managed care fees, use an attorney while you await a settlement, or other means of payment, we will assist you in filling for services rendered. Any outstanding balance for all services rendered and not paid, including the difference between the negotiated managed care insurance fees and the actual office fees presented to a third party or your attorney, will be your responsibility. Signing below acknowledges this responsibility. If you have a credit card, we would appreciate keeping a copy on account in the event there remains a balance. Professional collections services may be used to collect outstanding fees and their service charge may be added to your balance.

Patient's Signature: ____ Date_______/_______/________

Witness: ____

NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have the right to privacy regarding my health information. I understand that this information can and will be used:

- **Conduct, Plan and directly treat and follow-up among the multiple health care providers who may be involved directly and indirectly with treatment.**
- **Obtain payment from third party payers.**
- **Conduct normal healthcare operations such as quality assessment and physician certifications.**

I have received, read and understand your notice of privacy practice containing a more complete description of the use and disclosures of my health information. I understand that this organization has the right to change its police practices from time to time and that I may contact this organization at any time to receive a current copy of the notice of privacy practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patients Name: ____

Signature: ____

Date: ___________________________________ Relationship to patient: _________________________

Witness: ____