MOTOR VEHICLE COLLISION QUESTIONNAIRE

Please print Give complete answers to all questions. This information is confidential. Your input will help determine if chiropractic can help you.

Patient Information

Last Name **First Name** **Middle Initial** **Today's Date**

Address **City** **State** **Zip**

SSN **Age** **Birth Date** **Sex** **Phone**

Employer **Occupation** **Work Phone**

Address **City** **State/Zip** **Cell Phone**

Accident Information

Give details of how the accident occurred:

Date/time injury occurred: Month: Day: Year: Time: AM □ PM □

At time of accident, what direction were you going? North □ South □ East □ West □ On: _____
In what direction was the other vehicle headed North □ South □ East □ West □ On:

Did the other vehicle strike you from the: …… front □ back □ left side □ right side □
Were you: …… Driver □ Passenger □ Using seat belt □
If passenger were you: ……. front seat □ back seat □ left side □ right side□

	Yes	No
Were the police notified? ……..	□	□
Were you knocked unconscious? How long?……	□	□ _____
Was any other doctor consulted after your accident?……..	□	□
Have you ever injured this same area before? ……	□	□
Before this injury, were you able to work on an equal basis with others your age? ……	□	□
Has this accident restricted you work performance? ……	□	□

In what exact area did you feel pain immediately after the accident? _____

What treatment did you receive? _____

Did you consult another doctor? Yes □ No □ Name: _____Phone _____

Diagnosis: _____Treatment: _____

How often did you see the doctor? _____Over what period: Days : _____Weeks: _____Months: _____

If you had prior injuries in the same place describe them _____

Since the injury, are your symptoms: Same □ Better □ Worse □

Health Survey

SION

Musculoskeletal

_____Low back problems
_____Pain between shoulder**s**
_____Neck problems
_____Arm problems
_____Leg problems
_____Swollen joints
_____Painful joints
_____Stiff joints
_____Sore muscles
_____Weak muscles
_____Walking problems
_____Ruptures
_____Broken bones

Cardiovascular

_____Chest Pain
_____Pain over heart
_____Difficult breathing
_____Persistent cough
_____Coughing phlegm
_____Coughing blood
_____Rapid heartbeat
_____Blood pressure problems
_____Heart problems
_____Lung problems
_____Varicose veins

Gastrointestinal

_____Poor Appetite
_____Excessive hunger
_____Difficult chewing
_____Excessive thirst
_____Nausea
_____Vomiting food
_____Vomiting blood
_____Abdominal pain
_____Diarrhea
_____Constipation
_____Black stool
_____Hemorrhoids
_____Liver trouble
_____Gall Bladder problems
_____Weight trouble

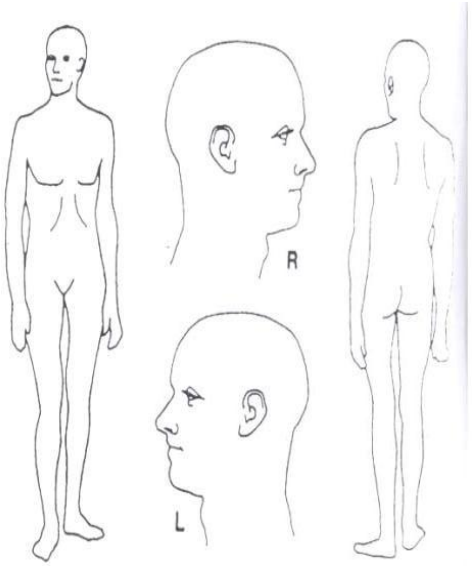
Nervous System

_____Numbness
_____Loss of feeling
_____Paralysis
_____Dizziness
_____Fainting
_____Headaches
_____Muscle jerking
_____Convulsions
_____Forgetfulness
_____Confusion
_____Depression

Eye, Ear, Nose & Throat

_____Eye strain
_____Eye inflammation
_____Vision problems
_____Ear pain
_____Hearing loss
_____Ear discharge
_____Nose pain
_____Nose bleeding
_____Nose discharge
_____Difficult speech
_____Sore gums
_____Dental problems
_____Sore mouth
_____Sore throat
_____Hoarseness
_____Difficult breathing

Mark areas of pain resulting from accident on figures below:



Genitourinary

_____Bladder trouble
_____Excessive urination
_____Scanty urination
_____Painful urination
_____Discolored urine

Female

_____Vaginal discharge
_____Vaginal bleeding
_____Vaginal pain
_____Breast pain
_____Lumps on breast

Are you pregnant? __Yes __No

Any fee for collecting outstanding balances will be the patient's responsibility.

Signature_____Date: _____

Consent, Release, and Authorization Form

Date: _____ Time: _____ AM/PM

Diagnostic x-rays may be advisable in my case so that a complete analysis can be made of my present musculoskeletal problem (or illness). If x-rays are determined to me necessary I authorized Dr. Hengel to perform such radiographic examination necessary to diagnose and to administer whatever treatment is deemed necessary to treat my condition. (To the best of my knowledge I am not pregnant and diagnostic x-rays are permitted).

Authorization to Release Information

I authorize the doctor and his staff named below to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequence thereof. I agree that a photostatic copy of this agreement shall serve as the original.

Notice of Assignment

I hereby authorize and direct payment of any medical and surgical expense benefits allowable to the doctor named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness the assignee. I agree that a photostatic copy of this agreement shall serve as the original. As of this notice I request that the name, Edward A. Hengel, D.C., be included on any payment for my treatment.

Signature _____ Date: _____

Assignment and/or release authorization is granted to:

Affton Lemay Chiropractic Center. L.L.C.

Edward A. Hengel, D.C.

4006 Bayless Avenue

St. Louis, MO 63125

314-631-5550

Affton Lemay Chiropractic Center Financial Policy

GROUP OR INDIVIDUAL INSURANCE: Your insurance is an agreement between you and your insurance company, not between your insurance company and this chiropractic office. We are not certain if your insurance covers chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. Because of this difference between policies, we expect that each patient who wishes to file insurance claims through this office, pay the insurance policy deductible and the patient's percentage or copay as stated in your policy. As a courtesy to our patient's our office will complete any necessary insurance forms at no charges. If your insurance company fails to process the claims after a second submission you will be required to pay for services and seek reimbursement from your insurance company. It is to be understood and agreed that services rendered are charged to you directly and you are personally responsible in the event that your insurance company denies payment. We will assist you in verifying your insurance coverage however, it is your responsibility to know the provisions of your particular policy. When all insurance checks have been received, we will refund any overpayment to you.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS Please present your auto insurance forms as soon as possible. If any attorney is handling your case, please notify our insurance personnel right away. Although you are ultimately responsible for your bill, our office will wait for settlement to be paid as long as you are an active patient and do not have major medical or medical payments coverage. We do not accept provider discounts because the liability carrier or medical payments coverage is the primary insurance company all others are secondary. If you suspend or terminate care, any fees and services are due immediately. We will contact your attorney and insurance companies to begin settlement procedures upon release from active care. If your case is not settled within 90 days from your release, we will require you to make partial payments of 20% of your outstanding balance for the next 5 months. At any point settlement is reached, your account is due and payable in full immediately.

ON THE JOB INJURY: Worker's Compensation pays in full for Chiropractic care when approved by your employer. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

** Regardless of which plan you are under, you will be required to pay for all products, durable supplies, orthotics, nutritional supplements etc. at the time they are provided to you.

Note: Your health information will be kept confidential. Any information we collect about you will be kept confidential in our offices. If a claim is submitted to an insurance provider you health information may be shared with the insurance company. The insurance company will keep your information confidential.

Any fee for collecting outstanding balances will be the patient's responsibility

Signature _____ Date _____

INCLUDE –or- ATTACH ALL PERSONAL INJURY INFO NEEDED FOR BILLING

PATIENT NAME		
STREET		
CITY		
STATE & ZIP		
TELEPHONE		
SOC. SEC #		
DATE OF BIRTH		
AGE AND SEX		

SEND BILL TO:

- ☐ **ATTORNEY ONLY**
- ☐ **ATTORNEY + INSURANCE**
- ☐ **AUTO INSURANCE**

CONDITION IS RELATED TO:

- ☐ **AUTO ACCIDENT**
- ☐ **OTHER ACCIDENT**
- ☐ **EMPLOYMENT**

PI - INSURANCE COMPANY INFO		SECONDARY INFO	ATTORNEY NAME
NAME			
STREET			
CITY			
STATE & ZIP			
PHONE			
POLICY #			
CLAIM #			
INSURED NAME			
ADJUSTOR NAME			
ADJUSTOR PHONE			
DATE OF ACCIDENT			

AUTHORIZATION TO RELEASE MEDICAL INFORMATION I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

AUTHORIZATION TO PAY BENEFITS I HEREBY AUTHORIZE PAYMENT OF THESE REASONABLE CHARGES TO Radiology Consultants Midwest FOR SERVICES RENDERED TO ME IN ACCORDANCE WITH §430.225, §430.230 RSMo, UPON ALL CLAIMS, COUNTER CLAIMS, DEMANDS, SUITS, OR RIGHTS OF ACTION BY ME AGAINST THE DEFENDANT/LIABLE PARTY IN WHICH ALLEGED LIABILITY IS INSURED. I AUTHORIZE PAYMENT DIRECTLY TO Radiology Consultants Midwest BENEFITS THAT WOULD NORMALLY BE DUE ME. I HEREBY AUTHORIZE MY ATTORNEY TO PAY DIRECTLY TO THE PROVIDER SUCH SUMS WHICH MAY BE DUE AS A RESULT OF THIS ACCIDENT AND TO WITHHOLD SUCH SUMS FROM ANY SETTLEMENT, JUDGMENT OR VERDICT AS MAY BE NECESSARY TO ADEQUATELY PROTECT Radiology Consultants Midwest.

AGREEMENT TO PAYMENT TERMS I AGREE TO REMIT IN FULL ANY BALANCE WHICH IS NOT COVERED OR PAID IN FULL BY ANY INSURANCE CARRIERS OR OTHER PARTIES THAT MAY HAVE RESPONSIBILITY OR LIABILITY FOR THE SERVICES RENDERED.

PATIENT SIGNATURE _____ PARENT/GUARDIAN _____ DATE _____

RADIOLOGY CONSULTANTS/MIDWEST
201 ENCHANTED PARKWAY
BALLWIN, MO 63021

(636)256-7779
(636)227-0624 FAX
FED ID # 43-1912520

AFFTON LEMAY
CHIROPRACTIC CENTER
DR. HENGEL
NPI: 1669566410

COMMENT or QUESTION:

RCM OFFICE USE ONLY

C/S 2 3 5 7 B _____
T/S 1 2 _____
L/S 2 3 4 5 B _____
PELVIS _____
F/S 1 2 _____

_____ _____
_____ _____

RADIOLOGIST 1 2 3

Name: _____Date of Injury: _____

So we may best serve you, please provide us with as much insurance information as possible.

Primary Coverages in a Motor Vehicle Collision

Medical pay benefits are benefits provided in the injured party's automobile insurance policy, which may provide payment for services up to a certain limit.

Filing for these claims should not affect the injured person's premium or eligibility for further coverage

Automobile Insurance (Medical Pay):

Name of Insurance Company: _____

Adjustor's Name: _____

Mailing address for claims: _____

_____

Insurance Company's Telephone #: _____Fax#: _____

Policy #: _____Claim #: _____

Automobile Insurance of Person at Fault:

Name of Insurance Company: _____Adjustor's Name: _____

Name of person who hit you: _____

Mailing address for claims: _____

_____

Insurance Company's Telephone #: _____Fax#: _____

Policy #: _____Claim #: _____

Attorney's Information

Name: _____Phone #: _____

Address: _____

_____

Secondary Coverages

Regular health insurance or peripheral policies will only be used as a last resort for coverage in a motor vehicle collision when all other primary liabilities are either exhausted or absent.

Primary Health Insurance Company: _____Phone #: _____

Address: _____

_____

Identification #: _____Group #: _____

If you have a secondary health insurance please write information on the back of this page. Thank You!