Family First Wellness Center

Automobile/PI Accident Questionnaire

____ _____________ ___________
Patient's Name **DOB** **HR#:**

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 chiropractic 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.

Please explain in detail how your accident happened. ____
____
____
____
What were the **time and date** of present injury? ____

Where did you feel pain immediately after the accident? ____

List the extent of your injuries as you know them: ____
____
____

Did you require post accident hospitalization? Yes/ No

Check symptoms you have noticed since the accident:

_____Headache	_____Dizziness	_____Depression	_____Fatigue
_____Light Bothers Eyes	_____Buzzing in Ears	_____Diarrhea	_____Neck Pain
_____Head Seems too Heavy	_____Memory Loss	_____Feet Cold	_____Neck Stiff
_____Pins and Needles in Arms	_____Ears Ring	_____Hands Cold	_____Fainting
_____Sleeping Problems	_____Back Pain	_____Face Flushed	_____Loss of Balance
_____Pins and Needles in Legs	_____Constipation	_____Tension	_____Nervousness
_____Numbness in Fingers	_____Loss of Smell	_____Fever	_____Irritability
_____Numbness in Toes	_____Loss of Taste	_____Chest Pain	_____Cold Sweats
_____Shortness of Breath	_____Stomach Upset		

Symptoms other than above: ____
____

Where were you taken after the accident? ____

Hospitalized? Yes/ No If yes, admitted? _____________How long? _____________

Name of Hospital____

Name of Doctors ____

What treatment was given? ____

Was any other doctor consulted after your accident? Yes/ No

JDD, DC 5/2011

Patient's Name	**DOB**	**HR#:**

If so, what was the doctor's name? ____________________ D.C., M.D., D.O., D.D.S.

What was the diagnosis? ____

What treatment was given?____

How often did you see the doctor? ____

How long did you see the doctor? ____

Have you ever had any complaints in the involved area before? Yes/ No

If so, what were the complaints? ____

Before the injury were you capable of working on an equal basis with others your age? Yes/ No

Are your work activities restricted as a result of this accident? Yes/ No

Since this injury are your symptoms, Improving? Getting worse? Same?

Automobile Insurance Company__________________________ **Policy No.** ________________

Accident Claim number _____________________

Name of your insurance adjustor _________________________**Ph #**______________________

Driver of other Vehicle _________________ Ins. Co. _________________ Policy #_____________

Have you retained an attorney? Yes/ No

If so, his/her name and address____

You were heading North/ East/ South/ West on ________________(street or highway)

Other vehicle was heading North/ East/ South/ West on ___________(street or highway)

Were police notified? Yes/ No

Were you knocked unconscious? Yes/ No If so, for how long? _____________________________

You were struck from Behind/ Front/ Left Side/ Right Side__________________________________

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts___________________________

Patient's Name	DOB	HR#:

Patient signature	DATE

Doctor signature	DATE

Office of Insurance Regulation
Bureau of Property & Casualty Forms & Rates Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services set forth below were actually rendered. This means that those services have already been provided.

____

____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment of services) or Guardian of Insured Person:

_________________________________ _________________________________ ____________

Insured Person's Name (*Print or Type Name)* Insured Person's Signature Date

The undersigned licensed medical professional affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. I have explained the services rendered to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to t**ruthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled,** or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment / Services or Medical Director (Signature by his or her own hand)

_________________________________ _________________________________ ____________

Physician's Name (*Print or Type Name)* Physician's Signature Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

ASSIGNMENT AND AUTHORIZATION OF INSURANCE BENEFITS

I,_______________________________________, the undersigned, for good and valuable consideration, including the agreement of Family First Wellness Center ("Assignee") to accept this assignment in lieu of demanding full payment for services on the date each service is rendered, I authorize and direct any insurance company that may be obligated to provide insurance benefits to me, or on my behalf, ("my insurance company") to accept billing and pay directly to Assignee such sums as may be due and owing Assignee for services rendered to me, both by reason of accident or illness, and by reason of any other bills that are due Assignee; and to withhold such sums from any disability benefits, medical payments benefits, no-fault benefits, or any other insurance benefits obligated to reimburse me or any form of settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Assignee.

I hereby further give lien to said Assignee 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 Assignee. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided.

In the event my insurance company refuses to make such payments, I hereby assign and transfer to Assignee any and all causes of action that I might have or that might exist in my favor against my insurance company. I further authorize and direct you, my insurance company to provide fifteen days advance notice to Assignee of any physical examination or examination under oath of myself that is scheduled by any insurance company.

I authorize and direct you, my insurance company and/or my attorney to release a copy of the payment record (PIP Payout Log) without redacting the names of payees and amounts paid and to release a copy of the declarations page of insurance policy and any pertinent information necessary for me to receive treatment and for Assignee to timely process claims. I also authorize Assignee to release any information pertinent to my care to any insurance company, adjustor, or attorney to facilitate collection under this Assignment and Authorization. I agree that a photocopy of this document may serve as the original.

I,_______________________________________, have read and fully understand the above information and agree to receive chiropractic care under these terms.

Patient Signature: ____ Date:__________________

Witness Signature: ____ Date:__________________

COMPLETE IF PATIENT IS A MINOR CHILD ________________________________ (Child's Name)

I, ____ being the parent or legal guardian of the above minor child have read and fully understand the above information and agree for my child to receive chiropractic care under these terms.

Signature: ____ Date :___________________

PROVIDER'S LIEN

To Attorney: ____

Address: ____

____

Phone # ____________________________ Fax # _____________________________

From: Patient ____

I do hereby authorize Family First Wellness Center, "FFWC" to furnish you, my attorney, with examination reports, diagnosis, treatment, prognosis, etc. of myself in regards to the accident in which I was involved and am receiving treatment for from FFWC.

I fully understand that I am directly and fully responsible to FFWC for all chiropractic bills submitted by them for services rendered to me. This agreement is made solely for FFWC's additional protection and in consideration of their awaiting payment.

I hereby give a Lien on my case to FFWC against any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries for which I have been treated. As such, I hereby authorize and direct you, my attorney, to pay directly to FFWC such sums that are due and owing FFWC for chiropractic services rendered to me, both by reason of this accident and by reason of any other bills that are due FFWC. I further direct you, my attorney, to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect FFWC.

Date: ____________Patient's Signature: ____

This signed document acts as my express authorization for you, my attorney of record, to sign in agreement for your intention on my behalf to observe the terms agreed to above and withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect FFWC.

Date: ___________ Attorney's Signature: ____

Please date, sign, and return one copy to the doctor's office. Keep a copy for your records. A photo copy of this form shall be considered as valid as the original.