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PERSONAL INJURY INTAKE / CONSENT FORM

Section A – Patient Data

Name: _____ DOB: _____SS #: _____

Previous Chiropractic Care: ( ) Yes ( ) No Date of Last Adjustment: _____ Reason for ending Care _____

Section B – Accident Data

Date of Accident: _____ Were you At Fault? ( ) Yes ( ) No First Visit at our office: _____

Section C – MedPay/PIP

Policy Holder: _____ SS Number: _____ DOB: _____

Insurance Company: _____ Policy # _____

Claim # _____ Phone_____ Fax _____

Claims Address _____

Adjuster: _____ Phone _____ Fax_____

Email _____

$ Amount Available _____ $ Amount Remaining _____

Accident Reported: Yes or No **Medical Claim Opened**: Yes or No **Will benefits pay directly to provider:** Yes or No

Section D – Adverse/Liable Party

Policy Holder: _____ SS Number: _____ DOB: _____

Insurance Company: _____ Policy # _____

Claim # _____ Phone_____ Fax _____

Claims Address _____

Adjuster: _____ Phone _____ Fax_____

Email _____

Accident Reported: Yes or No **Medical Claim Opened**: Yes or No **Will benefits pay directly to provider:** Yes or No

Section E – Attorney

Attorney Name: _____ Phone _____Fax_____

Receive claims/notes: Along the way or End of Care

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Section F – Auto Injury

Were You: ( ) Driver ( ) Passenger ( ) Pedestrian ( ) Bike Rider ( ) Motorcycle Driver

What is your chief complaint: _____

What was your vehicle speed: _____ Did you strike something: ( ) Yes ( ) No – If so what: _____

Were you struck from: ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked

What was speed of other Vehicle _____

What part of their vehicle was impacted: ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked

Did you impact anything inside the vehicle: ( ) Yes ( ) No If yes, what body part: _____

Were you wearing seatbelt: ( ) Yes ( ) No

What were your immediate feelings/reaction following accident:

( ) No discomfort	( ) Intense Pain	( ) Felt popping or ripping	( ) Stunned ( ) Discomfort
( ) Unable to Walk	( ) Lost consciousness	( ) Frightened	( ) Unable to exit vehicle w/o help

Did you require post-accident hospitalization? ( ) Yes ( ) No Have you had X-rays taken: ( ) Yes ( ) No

Have you lost any days of work? ( ) Yes ( ) No Since the accident have your symptoms changed? ( ) Yes ( ) No

What do you do to make it feel better: _____

Do you have any activity intolerances? ( ) Yes ( ) No If yes, what: _____

Describe the pain: (dull, ache, sharp, stabbing, tingling, etc) _____

Pain Intensity (1-10) _____ Do you wake up with pain: ( ) Yes ( ) No

Does it radiate anywhere ( ) Yes ( ) No If yes, where_____ What percentage of the day do you feel pain: _____

Check any symptoms you have experienced since the accident

- ❑ **Headache**
- ❑ **Neck Pain**
- ❑ **Neck Stiff**
- ❑ **Dizziness**
- ❑ **Back Pain**
- ❑ **Nervousness**
- ❑ **Tension**
- ❑ **Irritability**
- ❑ **Chest Pain**
- ❑ **Lights Bother Eyes**
- ❑ **Loss of Memory**
- ❑ **Ears Ringing**
- ❑ **Face Flushed**
- ❑ **Buzzing in Ears**
- ❑ **Loss of Balance**
- ❑ **Fainting**
- ❑ **Loss of Smell**
- ❑ **Loss of Taste**
- ❑ **Diarrhea**
- ❑ **Cold Hands or Feet**
- ❑ **Stomach Upset**
- ❑ **Constipation**
- ❑ **Cold Sweats**
- ❑ **Fever**
- ❑ **Pins & Needles in Arms**
- ❑ **Pins & Needles in Legs**
- ❑ **Numbness**
- ❑ **Depression**
- ❑ **Shortness of Breath**
- ❑ **Other_____**

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Complete One option below that applies to your claim

You were NOT at fault and wish to have the at-fault driver's insurance company pay for your medical bills.

If this is the way you wish to file, the insurance company will not pay claims until your case is closed and therefore all charges incurred at our office will be your responsibility to pay.

Other Party's Insurance Company: _____ Claim #_____

Is there a medical claim? Yes No **Can we release your medical records?** Yes No

Adjuster Name: _____ Phone # _____

Address: _____ Fax # _____

I understand the information listed above and will pay for all charges incurred at Summit Spine and Therapy.

_____ _____

Signature **Date**

You would like your claims submitted to your personal auto insurance company for payment. Payment will be made directly to Summit Spine and Therapy.

Auto Insurance Company: _____ Claim #_____

Is there a medical claim? Yes No **Can we release your medical records?** Yes No

Adjuster Name: _____ Phone # _____

Address: _____ Fax # _____

I understand the information listed above and will pay for all charges incurred at Summit Spine and Therapy.

_____ _____

Signature **Date**

Authorization for the Release of Medical Records

Patient Name:_____Date of Birth:_____

I hereby request and authorize: Summit Spine & Therapy
5750 E 91st St Suite B
Indianapolis, IN 46250

To Disclose information To and/or From:

Company/Name:_____

Address:_____

Phone/Fax/Email: _____

To Release the following information:

____ Entire medical record: (Including but not limited to: patient histories, notes test results, films, referrals, consults, billing records, insurance records, records received from other providers)
____ Other: _____

I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in accordance with this authorization. If this authorization has not been revoked, it will terminate 5 years from the date of my signature.

I understand this practice will not condition treatment or eligibility for care on my providing this authorization.

I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient: _____ Date: _____

Patient/Legal Representative: _____

If Legal Representative, relationship to Patient: _____

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

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PATIENT RECORDS AND DOCTOR'S LIEN

TO: ATTORNEY/INSURANCE CARRIER

Provider:
Summit Spine and Therapy
5750 E. 91st Street, Suite B
Indianapolis, IN 46250

Patient Name: _____Date of Incident: _____

I do hereby authorize the above provider to furnish you, attorney/insurance carrier, with a full report of his/her case history, examination, diagnosis, treatment, and prognosis of myself in regard to the incident in which I was recently injured – noted above.

I hereby give a lien to said provider on any settlement, judgment, or verdict as a result of said injury/illness, and authorize and direct you, attorney/insurance carrier, to pay directly to said provider such sums as may be due and owing him/her for services rendered me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect said provider adequately.

I fully understand that I am directly and fully responsible to said provider for all bills submitted by him/her for service rendered me, and that this agreement is made solely for said provider's additional protection and in consideration of his/her awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee. I agree to promptly notify Summit Spine and Therapy of any change or addition of attorney(s) or insurance carriers used by me in connection with this incident/accident, and I instruct any attorney/adjuster to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s)/adjusters.

I further agree to be fully responsible for reasonable attorney's fees and costs that have accrued due to the pursuance of payment of my account. I understand that if my attorney/insurance carrier does not wish to cooperate in protecting the provider's interest by signing this document, Summit Spine and Therapy will not await payment but may declare the entire balance due and payable at the time of service.

Patient's Signature: **X** _____ Dated: _____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately the above named provider.

Attorney's Signature: _____ Dated: _____

Please sign, retain a copy for your records, and return this copy to us promptly.