Auto Accident Questionnaire

Name:_____**Date of accident:** _____
(Print please)

Your role was (circle one): Back seat passenger, Front seat passenger, Driver with (left/right) hand on the wheel, Driver with both hands on the wheel, Driver of motorcycle, Passenger on motorcycle

What was the vehicle's status totaled/drivable? _____

What area of the vehicle was impacted? _____

It was (circle one): Dawn Dusk Full Daylight Night

Road conditions were (circle one): Damp Dry Icy Nasty Snow covered Wet

Rate the visibility (circle one): Excellent Fair Good Poor

What type was the other vehicle involved? _____

What would you guess was the speed of the other vehicle? (End in 0 or 5) _____

Was your headrest in the proper upright position? Yes No

Were you admitted to a hospital? Yes No
If yes, was it at the time of the accident or at a later time? _____

How did you get to the hospital? _____

What hospital were you seen at? _____

How long were you in the hospital? _____

Choose one –
_____I was able to brace for impact with my (hands, feet, or knees).
_____I was aware the accident was coming, but unable to brace.
_____I was not aware the accident was impending.

Circle the problem for the accident: Brightness Darkness Fog Rain Snow Traffic

Where are your injuries? _____

_____

X _____ _____
Signature of Patient, Parent, Guardian, or Personal Representative **Date**

Assignment of Benefits:

Assignment of Cause of Action: Contractual Lien

Fisher Chiropractic
Jeff Fisher, D.C.
320 Palo Pinto St.
Weatherford, TX 76086
Telephone: (817)-594-1505

The undersigned patient and/ or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to Jeffery D. Fisher, DC, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits, including any Personal Injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all the following rights, power, and authority:

_____ **Initial** **I authorize the release of any records completed and/or obtained by Fisher Chiropractic to my insurance company, attorney, referral physician and/or insurance adjustor.**

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.
DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment upon violation. I further instruct my carrier to make all checks payable to Fisher Chiropractic, and send to 320 Palo Pinto St., Weatherford, TX, 76086.
THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to Fisher Chiropractic, and to send any and all checks to 320 Palo Pinto St, Weatherford, TX 76086.
STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.
LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.
REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/ clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are no adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.
TERMINTATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. IF during the course of my care, my insurance company requires me to take an examination from any other doctor; I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.
Signature of Patient and/or Responsible Parties:
I declare under penalty of perjury that the forgoing is true and correct. [CPRC: Sec.132.001 (a)]

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative **Date**

X _____ _____

Signature of Witness **Date**

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score

FISHER CHIROPRACTIC PATIENT CASE HISTORY

Name: _____

Address: _____

City _____ State: _____ Zip: _____

Home Phone: ___ - ___ - ____ Cell Phone: ___ - ___ - ____

Email Address: _____ Employer/Occupation: _____

Date of Birth: ___/___/____ Social Security #: ___ - ___ - ____ Gender: Male -- Female

Marital Status: M S W D How many children? _____ Name of Spouse: _____

Emergency Contact: _____ Relationship: _____ Phone: ___ - ___ - ____

Referred by: _____

Please inform us if you are using any form of insurance.

Reminder: If using insurance your coverage is a contract between you and your insurance company, not between you and our office. You are responsible for all charges on your account, including charges not paid in full by your insurance company.

List any **Allergies:** _____

Mark any **Surgeries**:

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Knee ☐ Neck ☐ Neurological ☐ Shoulder ☐ Wrist

Other: _____

Mark **ALL Past Medical History:**

☐ Ankle Pain	☐ Arm Pain	☐ Arthritis
☐ Asthma	☐ Back Pain	☐ Broken Bones
☐ Cancer	☐ Chest Pain	☐ Depression
☐ Diabetes	☐ Dizziness	☐ Epilepsy
☐ Eye/Vision Problems	☐ Fainting	☐ Fatigue
☐ Foot Pain	☐ Genetic Spinal Condition	☐ Hand Pain
☐ Headaches	☐ Hearing Problems	☐ Leg Pain
☐ Menstrual Problems	☐ Mid-Back Pain	☐ Minor Heart Problems
☐ Multiple Sclerosis	☐ Neck Pain	☐ Neurological Problems
☐ Pacemaker	☐ Parkinson's	☐ Polio
☐ Prostate Problems	☐ Shoulder Pain	☐ Significant Weight Change
☐ Spinal Cord Injury	☐ Sprain/Strain	☐ Stroke/Heart Attack

Other: _____

_____

Mark the type of **Medications** you are taking:

☐ Anxiety	☐ Muscle Relaxers	☐ Pain Killers	☐ Cardiovascular
☐ Insulin	☐ Allergy	☐ Seizure	☐ Birth Control

Other: _____

Mark your **Family History:** Please indicate who in your family has the condition

	Mother	Father	Sister	Brother	Child
Arthritis					
Back Pain					
Cancer					
Depression					
Diabetes					
Spinal Condition					
Headaches					
High blood Pressure					
Heart Problems					
Stroke/Heart Attack					

Other: _____

_____

_____

_____

_____

Have you had any auto or other accidents? Yes No

Describe:_____

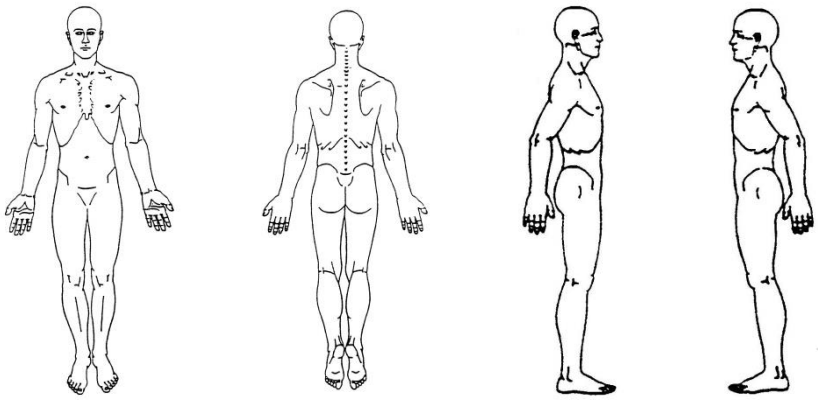
Date of last Physical Examination: _____/_____/_____

Do you smoke? No Yes **Do you drink alcohol?** No Yes --- **how many per day**? _____

Do you drink caffeine? No Yes --- how many per day?_____

Do you exercise? No Yes (What forms and how often):_____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main Reason for consulting the office:

- Become Pain free
- Explanation of my condition
- Learn how to care for my condition
- Reduce symptoms
- Resume normal activity

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Fisher Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Fisher Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

X _____ _____

Signature of Patient, Parent, Guardian, or Personal Representative **Date**

FISHER CHIROPRACTIC

Privacy and HIPAA

_____ Initial **-This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at any time from the front desk. Please initial and sign at the bottom to indicate you have been made aware of its availability. *I also understand there is a possibility my conversations may be overheard since there are no doors on the exam rooms. I may request, prior to my appointment, to have time set aside to discuss matters in a more private manner.***

Informed Consent to Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other therapy procedures to be performed on myself by the doctor. I also consent to the procedures performed by his trained staff assistants under direct instruction and supervision.

I have had an opportunity to discuss with the doctor or other office personnel the nature and purpose of chiropractic adjustments and other therapy procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee to results has been made to, nor relied upon by, me, and I wish to rely on the doctor to exercise judgment during the course of the procedures which he feels at the time, based upon the facts then known, is in my best interests.

I have also been advised that although the incidence of complications associated with chiropractic procedures is very low, anyone undergoing chiropractic adjustments, physical therapy services or joint manipulation procedures should know of possible complications, which have been alleged. These include, but are not limited to; burns, fractures, disc injuries, strokes, dislocations, sprains, increase or worsening of symptoms and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I have read or have had read to me the above Consent. I have also had the opportunity to ask questions about its' contents, and by signing below, acknowledge my understanding of its contents.

_____

Please print name of Patient

X

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative **Date**

Patient-Doctor Agreement

Initial **ONE** CORRECT FORM OF PAYMENT

The purpose of this agreement is to make sure we are able to best serve you. The scheduled appointments are made for a reason, they attempt to keep patient wait times down and allow for the best patient care possible.

_____Initial **CASH PATIENT FINANCIAL POLICY –** All fees are due at the time of service unless pervious arrangements have been made with this office. For your convenience, future payments may be arranged at the first visit of each week. We are happy to **accept** cash, check, MasterCard, Visa, Discover, and American Express. We **do not** accept Care Credit.

_____Initial **MEDICARE –** Original Medicare covers 80% of approved services after the deductible is met. Medicare **does not** pay for evaluations, re-exams, or x-rays. Medicare **will not** pay for maintenance care, but episodes of care where notable progress is being made.

_____Initial **MAJOR MEDICAL/GROUP INSURANCE –** Payment is expected at time of visit, whether it is a co-pay or towards a deductible. Please give all insurance information (secondary policies included) to the Front Desk C.A. along with a copy of your card(s). Also, any payment sent to your home by the insurance company that is owed to Fisher Chiropractic must be brought to our office within three days.

_____Initial **AUTO ACCIDENT/PERSONAL INJURY –** Fees are **usually** covered 100% for these injuries; however, YOU are ultimately responsible for any balance on your account. When using PIP, personal injury protection, you are responsible for providing this office with the name of your insurance company and the adjustor's name and contact information. You are also responsible for reporting the accident to your insurance company/agent.

Phone Consent

! **I give Fisher Chiropractic my permission** to leave voice messages regarding my appointments, medical care and/or billing information on this number: _____

! **I give Fisher Chiropractic my permission <u>to discuss</u>** my medical care and/or billing information with the person(s) listed below:

Authorized Contact:_____ Relationship: _____

Authorized Contact:_____ Relationship: _____

X _____ _____

Signature of Patient, Parent, Guardian, or Personal Representative **Date**