MALINA CHIROPRACTIC
3826 N. Druid Hills Rd – Decatur Georgia 30033
Office 404-325-3609 Fax 404-325-8859

Car Accident Questionnaire

Name: _____ Age: _____Date of birth: _____ Date: _____
LAST FIRST MIDDLE

Address: _____Social Security #: _____ ☐ Male ☐ Female

City, State, Zip: _____Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children_____

Home Phone (_____)_____Work Phone (_____) _____

Cell Phone (_____) _____Email address: _____

Employer: _____ Spouse's Name: _____

Occupation: _____ Spouse's Employer: _____

In case of emergency, notify_____ Relationship: _____ Phone (_____) _____

Current Symptoms: 1._____ 2._____ 3._____ 4._____

5. _____ 6. _____ 7. _____ 8. _____

When did your symptoms begin? _____

In general what makes your symptoms better? _____

In general what makes your symptoms worse? _____

In general how would you describe your pain? (ache, burn, dull, sharp, throbbing): _____

Are your symptoms local or do they travel to another area? (If they travel, to where?) _____

Are symptoms; ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% **of your waking hours**

Were there any symptoms which you had after the crash that have now resolved? (please list)

_____

Please list all medications and dosage:	**Frequency**	**For What Illness?**

List any allergies to medications, foods or other: _____

Are you pregnant? ☐ Yes ☐ No First day of last menstrual cycle: _____

Do you smoke? ☐ Yes ☐ No; How much? _____ Do you drink alcohol? ☐ Yes ☐ No; How much? _____

Please list all serious illness and serious accidents:	**Month and Year**	**City, State**

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Patient's Name: _____ Date: _____

Please list any recent x-rays, lab or other tests: **Date** **Facility/Doctor**

_____

_____

Date of Crash: _____ Hour: _____AM _____PM _____

Specific Location of Crash: _____

Describe in detail, in your own words, how the crash/accident happened: _____

_____

_____

_____

AUTOMOBILE/MOTORCYLCE ONLY
In the crash: Were you the ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other? _____

Did your vehicle strike the other vehicle? ☐Yes ☐No Did the other vehicle strike your car? ☐Yes ☐No

Were you struck from? ☐ Behind ☐ Front ☐ Driver Side ☐ Passenger Side **Motorcycle Only**: ☐Left Side ☐ Right Side

Were traffic citations issued to? ☐ You ☐ Driver of Your Vehicle ☐ Driver of the Other Vehicle ☐ No Citations Given

Was your vehicle heading? ☐ North ☐ South ☐ East ☐ West on _____ (Street/Highway)

Was the other heading? ☐ North ☐ South ☐ East ☐ West on _____ (Street/Highway)

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE THE CRASH/ACCIDENT:

☐ Headache	☐ Middle Back Pain	☐ Lower Back Pain	☐ *Ears Ring*
☐ Neck Pain	☐ Chest Pain	☐ Lower Back Stiffness	☐ *Buzzing in Ears*
☐ Neck Stiffness	☐ Bruised Chest	☐ Radiating Pain	☐ *Dizziness*
☐ Sleeping Problems	☐ Bruising Anywhere	☐ Tingling in Legs	☐ Loss of Smell
☐ *Depression*	☐ *Blurred Vision*	☐ Tingling in Arms	☐ Loss of Taste
☐ *Anxiety*	☐ Sensitivity to Light	☐ Jaw Pain	☐ *Any Burns*
☐ *Fainting*	☐ Upper Arm Pain	☐ Upper Leg Pain	☐ *Any Stitches*
☐ Muscle Spasms	☐ Lower Arm Pain	☐ Lower Leg Pain	☐ *Any Cuts*

☐ Other Symptoms: _____

Have you lost time from work? ☐ Yes ☐ No: If Yes, Dates: _____ to _____

Where did you go after the crash? ☐ Hospital ☐ Urgent Care ☐ Home ☐ Work ☐ Other _____

Were you taken by ambulance? ☐ Yes ☐ No **To which hospital?** _____

Address: _____ Date of Hospitalization: _____

Attending E.R. Doctor: _____ Treatment Given? _____

Have you done any of the following since the crash:

☐ Ice	☐ Medication (name)_____	☐ Rest
☐ Heat (any kind)	☐ Exercise	☐ Other_____

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Patient's Name: _____ Date: _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

Tuberculosis ☐ Yes Lung Disease ☐ Yes Gout ☐ Yes Diabetes ☐ Yes
Kidney Disease ☐ Yes Stomach/Ulcer ☐ Yes Heart Disease ☐ Yes Hepatitis ☐ Yes
Sciatica ☐ Yes Blood Pressure ☐ Yes Transfusion ☐ Yes Polio / MS ☐ Yes
Colon Disease ☐ Yes Stroke ☐ Yes Cancer ☐ Yes Bleeding ☐ Yes
Paralysis ☐ Yes Seizures ☐ Yes Arthritis ☐ Yes Asthma ☐ Yes
Anemia ☐ Yes Thyroid Disease ☐ Yes Drug Dependence ☐ Yes AIDS ☐ Yes

PLEASE PROVIDE US WITH THE APPROPRIATE INSURANCE INFORMATION:

1) YOUR AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Telephone: (_____) _____ Insured: _____

Claim #: _____ Policy #: _____

Claim Representative: _____

Telephone: (_____) _____ Fax: (_____) _____

Med-Pay Benefits: _____ Uninsured (UM) Benefits: _____ Underinsured (UIM) Benefits: _____

Have you signed a selection waiver of benefits? ☐ Yes ☐ No ☐ Unsure

Are you a full time Student? ☐ Yes ☐ No Do you reside with a relative? ☐ Yes ☐ No

2) YOUR HEALTH INSURANCE COMPANY: _____

Address: _____ Insured: _____

Date of Birth: _____ Policy #: _____ SS#: _____

Telephone: (_____) _____ Fax: (_____) _____

3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Claims Rep: _____

Claim #: _____ Policy #: _____ Insured: _____

Telephone: (_____) _____ Fax: (_____) _____

4) ATTORNEY: _____ Legal Assistant: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____

HIPAA Compliance

Our office is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Staff Initials: _____

Malina Chiropractic

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(404) 325-3609

Authorization To Sign Medical Lien

I, _____, the undersigned, do hereby authorize and direct my attorneys to enter into an agreement with my health care provider, Malina Chiropractic, to ensure the payment of my medical bill to said health care provider from my portion of any settlement or verdict proceeds.

I further certify that I understand this authorization gives my attorney authority to deduct medical expenses from my portion of any recovery in my case. I instruct my attorneys to deduct sufficient monies to pay the outstanding medical bills due to Malina Chiropractic Clinic LLC and pay the sum of the medical lien to Malina Chiropractic without further written authority from me.

My attorneys are also authorized to release an accurate settlement statement to Malina Chiropractic.

My attorneys have explained to me that signing a lien to the extent necessary to cover the medical expenses is irrevocable; that is, I may not cancel or withdraw such consent to pay Malina Chiropractic Clinic LLC without Malina Chiropractic's written notarized authorization for me to cancel the lien.

I also understand that my health care provider has conditioned further treatment of me upon receiving the written assignment and lien on the proceeds of my claim.

_____ _____

Date Patient Signature

_____

Witness Signature

Malina Chiropractic

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LIEN AND AUTHORIZATION
INSURANCE BENEFITS AND ATTORNEY

Claim or File#: _____ Insured's Name: _____

Date of Loss: _____ Address: _____

Patient: _____ _____

Policy #: _____

To Whom It May Concern:

I hereby authorize and direct you, my insurance company, liability insurance adjustor, and/or my attorney, to pay directly to: **Malina Chiropractic** such sums as may be due and owing this Office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payments benefits, No Fault benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Office. I hereby further give a lien to said Office against any and all insurance benefits name 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 said Office.

I understand that I remain personally responsible for the total amounts due the Office for their services. I further understand and agree that this Lien and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I agree to pay all costs of collection of any balance due this Office, including reasonable attorneys' fees. This agreement is solely for said provider's additional protection and in consideration of the Medical Service Provider awaiting payment in this matter.

I authorize the Office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Lien and Authorization. I agree that the above mentioned Office be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill. I hereby instruct that in the event another attorney is substituted in this manner, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him. A photocopy of this Agreement shall be considered as effective and valid as the original.

Date: _____ Signed: _____

Witness: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect said doctor above named.

Date: _____ Signed: _____

Note to attorney: If you prefer, please send your acknowledgement of this lien on your letterhead.

MALINA CHIROPRACTIC
INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below.

As a part of the analysis, examination and treatment, you are consenting to the following procedures: Spinal manipulative therapy, palpitation, range of motion testing, orthopedic testing, basic neurological muscle strength testing, postural analysis testing, hold/cold therapy, spinal decompression, cervical traction, radiographic studies, vital signs and low level laser light therapy. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of these chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to, self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I also acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read or had the opportunity to read and understand the Notice.

PATIENT NAME:_____ TODAY'S DATE:_____

PATIENT SIGNATURE (Or Guardian's signature if Patient is a minor):_____

(If applicable) NAME OF GUARDIAN/RELATIONSHIP TO PATIENT:_____

NAME OF TREATING D.C. _____ SIGNATURE_____ DATE_____

OFFICE FINANCIAL POLICY

1. **If you DO NOT have insurance (Self-Pay):** All payments are due at the time of treatment or by an authorized payment plan. With the exception of authorized payment plans, your personal balance may not exceed $100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

2. **If you DO have insurance:** Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care. All deductibles, co-insurance and co-payments are the patient's responsibility and are due at the time of treatment or by an authorized payment plan. With the exception of an authorized payment plan, your patient responsibility balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a self-pay patient until you bring in your completed insurance forms and we qualify and accept your insurance coverage.

Our fees are considered usual, customary, and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

Not all services provided in our office are a covered benefit with all insurance contracts. Some insurance companies arbitrarily select certain services that they will not cover or which they have deemed not necessary. Your doctor will determine the best route of care for you based on your individual circumstances, not based on insurance coverage. If a treatment is not covered by your insurance, you will be responsible for the amount due for that treatment. We will make every effort to verify your coverage before treatment is rendered and will make you aware of your coverage. Please know this does not guarantee payment from your insurance carrier. If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid a claim within ninety (90) days of submission, you accept financial responsibility for payment in full of any outstanding balance. When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for treatment(s) will be due as it/they are rendered.

3. **Personal Injury/Third Party Claims:**

A. If You Have Medical Payments (MedPay or PIP) Coverage on Your Auto Policy: Whether or not you are the responsible (at fault) party involved in the accident, you are entitled to use your MedPay benefits to pay for your care. It is our policy that we will file on your MedPay coverage if you have it and may decline services if you refuse to use your MedPay coverage.

B. If You Have Health Insurance: We may be able to file your health insurance to assist in payment of your Personal Injury claim with the following conditions: a) MedPay benefits have been exhausted, and b) it is our policy that we will not file to carriers that do not allow us to balance bill for Usual and Customary Rates.

C. Liens: If you do not have MedPay coverage, we will consider taking your case on a lien basis at the discretion of the doctor. In most cases, you will need a lawyer representing you before we will agree to work on a lien.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim(s) submitted or any authorized payment plans. Returned checks are subject to a $35 handling fee. We will send a statement of your account with any thirty (30) day balances due. At sixty (60) days, you will receive a statement with late charges applied. At ninety (90) days, if we have not received payment on your past due balance, we will send the account to collections. If it becomes necessary to turn your account over for collection, you accept responsibility for any fees involved in that process.

By signing below, I acknowledge that I have fully read and understand the Office Financial Policy for Malina Chiropractic.

Patient's Printed Name: _____ Date:_____

Patient's Signature: _____

Witness Signature: _____

PREGNANCY RELEASE

This is to certify that to the best of my knowledge, I am not pregnant. The above doctor and his/her associates have permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

The date of my last menstrual cycle:_____

_____ _____

Patient Signature Today's Date