ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI)________________________ **Today's Date:** __________

AUTOMOBILE ACCIDENT – ADDITIONAL INFORMATION

- **Was anyone else in the vehicle with you?** ☐ No ☐ Yes - *(Number of people)* ______
- **You were?** ☐ Front seat – *Driver / Passenger* ☐ Rear Seat– Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row
- **Name of Driver**, *if not self*: ______________ **Name of Driver of other vehicle:** ______________
- **Did airbags deploy?** ☐ No ☐ Yes **Did Police arrive?** ☐ No ☐ Yes **Using Seatbelt?** ☐ No ☐ Yes
- **Did you strike the windshield or object in car?** ☐ No ☐ Yes - *(Describe)* ______________
- **Were you knocked unconscious?** ☐ No ☐ Yes *(How long?)* ________
- **Where was your vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: ______________
- **Where was the other vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: ______________
- **Your Auto Ins:** ____________ **Policy #:** ____________ **Claim #:** ____________ **Phone #:** ____________
  - **Address:** ______________ **City:** ____________ **State:** ______ **Zip:** ________
- **Other's Auto Ins:** ____________ **Policy #:** ____________ **Claim #:** ____________ **Phone #:** ____________
  - **Address:** ______________ **City:** ____________ **State:** ______ **Zip:** ________

WORKER'S COMPENSATION INJURY – ADDITIONAL INFORMATION

Employer: ______________ **Occupation:** ____________ **Claim #:** ____________
Address: ______________ **City:** ____________ **State:** ______ **Zip:** ________
Contact Person: ______________ **Phone:** ____________ **Email:** ____________

GENERAL ACCIDENT/INJURY INFORMATION – *(PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)*

Date of Accident: ___/___/_____ **Time:** ___:_____ AM / PM

Please describe the accident in as much detail as possible? ______________

____

____

____

Before the accident/injury:

- **Have you ever had any complaints in the involved area before?** ☐ No ☐ Yes
  - *If yes* - **Were they present at the time of the accident/injury?** ☐ No ☐ Yes
    - *If yes* - **Summarize these complaints prior to the accident:** ______________
- **Were you capable of performing all of your work activities without restriction?** ☐ No ☐ Yes

At the time of the accident/injury:

- **Did you feel pain immediately after the accident?** ☐ No ☐ Yes ☐ Later that day ☐ Next day ☐ When? ____________
- **Were you taken anywhere after the accident?** ☐ No ☐ Yes ☐ Later that day ☐ Next day ☐ When? ____________
  - *If yes*, **How?**______________ **Where?**______________
  - *If yes*, **Did you receive treatment?** ☐ No ☐ Yes - *(Describe)* ______________

Since the accident/injury:

- **Are your symptoms:** ☐ Improving? ☐ Getting Worse? ☐ The Same?
- **Are your work activities restricted as a result of this accident/injury?** ☐ No ☐ Yes - *(How?)* ______________
- **Have you missed any work since this accident?** ☐ No ☐ Yes - *(Dates?)* ______________
- **Have you retained an Attorney?** ☐ No ☐ Yes - **Name:**______________ **Phone:** ____________
  - **Address:** ______________ **City:** ____________ **State:** ______ **Zip:** ________

Patient No: __________

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Introduction Patient Case History

Today's Date: ____________

Patient Information

Name: (Last, First MI) ______________________________ **Preferred Name:** ____________

Address: ______________________ **City:** ______________ **State:** ______ **Zip:** ________

Home: ____________ **Mobile:** ____________ **Mobile Carrier:** ____________ **Work:** ____________

Email: ______________________ **Gender:** M / F **Marital Status:** Married / Other / Single

Social Security #: ______________________ **Date of Birth:** ______________________

Student Status: Full Student / Part Student / Non-Student ☐ **Employed** **Employer:** ______________

***Referred By:** ______________________

Ethnicity: Hispanic or Latino / Other

Preferred Language: ______________________

Race: Asian / African Am. / Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White

Smoking Status: Every Day / Some Days / Former / Never

Emergency Contact Information

Full Name: ______________________ **Primary Care Physician:** ______________________

Home: ____________ **Mobile:** ____________ **Doctor's Phone:** ______________________

Relationship: Child / Parent / Spouse / Other: ____________

Financial Information

☐ Insurance ☐ Worker's Comp ☐ Self-Pay (Cash) ☐ Personal Injury/Auto ☐ Other (please explain):________

Primary Insurance

Name: ______________________

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:
Insured's Name: ______________ **Gender:** M / F

Address: ______________________

City: ____________ **State:** _____ **Zip:** ________

Phone: ____________ **Date of Birth:** __________

Secondary Insurance

Name: ______________________

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:
Insured's Name: ______________ **Gender:** M / F

Address: ______________________

City: ____________ **State:** _____ **Zip:** ________

Phone: ____________ **Date of Birth:** __________

Who is responsible for payment? Self / Other - *(Relationship)* ______________

Other than Self:
Full Name: ______________________ **Phone:** ______________

Address: ______________________ **City:** ______________ **State:** ______ **Zip:** __________

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Patient No: __________

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MC-64

PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: ____________________

Began When? ___/___/____ **Describe how this began:** ____________________

____

____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: ____________

How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes *(Describe)* ____________

Head - Base of Skull / Forehead / Sides-Temple R / L / Both *Leg* - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm – Across Shoulder / Elbow / Hand-Fingers R / L / Both *Other Area:* ____________

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: ____________

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: ____________

Which daily activities are being affected by this condition? *(Describe)* ____________

For this CURRENT condition, have you:

- **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other: ________ **Where?** ________
- **Had any previous Surgery or Interventions in this area?** *(Describe)* ____________
- **Taken any Medications?** OTC / Prescriptions ____________
- **Had any diagnostic testing?** X-rays / MRI / CT / Other: ________ **When and Where?** ________

Describe any Secondary Complaints: ____________________

HEALTH HISTORY – *(PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)*

Medications:

Allergies to Medications: *NONE* *(List)* ____________

____

Current Medications: *NONE*

(Already have a list? We can make a copy.) ____________

____

____

____

____

Past Health History: *(Please list any past...)*

Surgeries – Date, Type, and Reason: *NONE*

____

____

____

____

Major Injuries/Traumas: *NONE* ____________

____

____

____

Major Hospitalizations: *NONE* ____________

____

____

Family Health History: *(Please mark N/A if not relevant.)*

List *relevant* major health problems of immediate relatives:

____

____

____

Deaths in immediate family: *(Cause and at what Age?)*

____

____

____

Social and Occupational History:

Level of Education Completed: ____________

High School / Some College / College Grad. / Post Grad. / Other

Lifestyle: *(Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)*

____

____

____

____

Habits:

Cigarettes – *(#/day)* ____________

Alcohol – *(amount/day)* ____________

Coffee/Tea – *(cups/day)* ____________

Rec. Drugs *(List)* ____________

Patient No: ________

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Functional Rating Index and Pain Assessment Scale

In order to properly assess your condition, we must understand how much your problems have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now**

Item							
1. Pain Intensity	No Pain	0	1	2	3	4	Worst Possible Pain
2. Sleep	Perfect Sleep	0	1	2	3	4	Disturbed Sleep
3. Personal Care	No Restrictions	0	1	2	3	4	Severe Pain; Need 100% assistance
4. Travel (driving)	No Pain on Long Trips	0	1	2	3	4	Severe Pain on Short Trips
5. Work	Can do usual work plus extra work	0	1	2	3	4	Cannot work
6. Recreation	Can do all activities	0	1	2	3	4	Cannot do any activities
7. Frequency of Pain	No Pain	0	1	2	3	4	Constant Pain; 100% of the day
8. Lifting	No pain with Heavy lifting	0	1	2	3	4	Increased pain with any weight
9. Walking	No pain; any Distance	0	1	2	3	4	Increased pain with all walking
10. Standing	No pain after Several hours	0	1	2	3	4	Increased pain with any standing

0 – 10 Numeric Pain Rating Scale

0 1 2 3 4 5 6 7 8 9 10

No Pain — Moderate Pain — Worst Possible Pain

Patient Signature: ______________________ Date: ____________

MEDPAY INFORMATION

A lot of people have medical benefits ("Medpay") included in their automobile policies, and do not even realize it. Our office highly recommends that you use your medpay coverage, if you have it, in the event that you've been injured in an automobile accident, regardless of who was at fault.

Here are 3 major reasons why we recommend that we file with your medpay.

1. Medpay is exactly like health insurance – using it does not cause your rates to increase. If your rates increase, it is not because you filed your medpay, it is mostly because (a) it was determined that you were at fault, (b) you received the police citation or ticket, or (c) you have been involved in numerous reported auto accidents within a brief period of time, and therefore are now considered to be "high risk".

2. Filing your medpay does not relieve the other party from having to pay in full for your loss. On the contrary, by filing your medpay, when you collect from the other driver's liability insurance, a greater amount of the settlement will go directly to you because your bill at our office will be less or even paid-in-full. If the other driver's liability insurance refuses to make payment to you for whatever reason, filing your medpay will help ensure that you are not stuck with all the medical bills.

3. If you have medpay coverage and choose not to file it, then you are paying for an option, but not receiving the benefits.

OUR OFFICE FINANCIAL POLICY

As long as our office is filing your medpay and insurance, and these companies are continuing to cover your charges, we will waive collection of payment at the time of service. If we receive overpayment on your account, we will be happy to refund you the difference. Any balance owing will become immediately due and payable, should your case not be settle within a reasonable time from your release from care.

Election to Pursue Liability Claim and NOT Health Insurance Claim

To Whom It May Concern:

The staff of Benningfield Chiropractic has advised me that the cost of my treatment for injuries sustained in an automobile accident that occurred on _________________ may be covered in whole or part by both my own health insurance and by the liability insurance of the party at fault.

Benningfield Chiropractic has informed me that if I file on my own health insurance, I will be responsible for paying deductible and co-payments and that any such payments will be due as treatment is received. Benningfield Chiropractic has also that if my health insurance makes any payments towards the cost of treatment and I successfully pursue a claim against the liable party, I may be required to reimburse my health insurer for any sums it has paid either to me or to my treating physicians.

I have decided that **I do not wish to file any claim on my health insurance.** I hereby direct and authorize Benningfield Chiropractic to send bills and treatment records only to my attorney, or to the liability insurance carrier, or to my own automobile insurer for the purpose of receiving payment under my Medical Payments, Uninsured or Under-Insured Motorist coverage, if applicable.

I understand that Benningfield Chiropractic will rely on my decisions and render treatment based on the assumption that payment will be received from sources other than my health insurance. I will not be expected to pay deductibles or co-payments, and third party payors will be billed at Benningfield Chiropractic's usual rates rather than at discounted rates that may apply to in-network providers.

I understand that if for any reason, my liability claim is ultimately denied, compromised or litigated unsuccessfully, I will remain personally liable for the reasonable value of the treatment rendered to me by Benningfield Chiropractic.

Today's Date is: ____

Patient: ____

Witness: ____

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of Benningfield Chiropractic to treat me on credit without demand for payment at the time services are rendered. I hereby agree and stipulate as follows:

I irrevocably assign to Benningfield Chiropractic any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on ______________________ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to Benningfield Chiropractic from any disability benefits, medical payment benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due to Benningfield Chiropractic for its services rendered.

I appoint Benningfield Chiropractic as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Benningfield Chiropractic.

I authorize Benningfield Chiropractic to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries prior medical history or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to Benningfield Chiropractic for services rendered, including any balance remaining after the application of insurance payment and settlement or judgment proceeds. If Benningfield Chiropractic is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Benningfield Chiropractic for its costs of recovery, including reasonable attorney's fees.

I further agree this assignment of benefits (AOB) cannot be revoked and the right to receive payment cannot be transferred to any other party or re-asserted by me in any way.

______________________________ ______________________

Patient Date

____

Witness

NOTICE OF LIEN

Pursuant of N.C.G.S 44-49 and 44-50, Benningfield Chiropractic hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

Benningfield Chiropractic hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S 44-50.1. Benningfield Chiropractic agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

Benningfield Chiropractic

By: ______________________________

Office Policies for Personal Injury Patient

This office will accept you as a new patient based on our clinical examination and belief that chiropractic care will be effective for the treatment of your injuries. Your responsibility to this office will be to follow the doctor's recommendations and to provide the appropriate financial information so that payment for services can be received.

Patients need to bring the following:

1. Copy of the police report and/or copy of the exchange slip.
2. Copy of your personal automobile policy (to verify medical payments covered by your automobile insurance)
3. Name of individual and insurance company of the party that is liable. Please include policy number.
4. Name and telephone number of attorney (if an attorney has been retained)

You are asked to give a 24 hour notice if you need to reschedule any appointment. All appointments that have been missed without notice may be billed to your account. If you have missed appointments and we have not heard from you for a 2 week period then we will assume you have decided to stop treatment. We will then forward your release paperwork to the liable party's insurance company and your attorney. You will also receive a copy of your bill for your records.

Following the completion of your treatment in this office, your bill will be forwarded to the responsible party. Please note that this account is still your responsibility.

Signature: ______________________________ Date: ________________

Authorization to Release Information

Patient: ______________________________

Address: ______________________________

Date of Birth: __________________________

I authorize any medical osteopathic or chiropractic physician, hospital, clinic, rehabilitation facility or other medical practitioner or provider who has or will be furnishing services to me to provide my medical information, including history, treatment, diagnosis and prognosis to Benningfield Chiropractic.

__________________________________ ______________________

Patient Signature Date

AUTHORIZATION

The following uses and/or disclosures specifically require your express written permission:

Marketing Purposes – We will not use or disclose your PHI for marketing purposes for which we have accepted payment without your express written permission. However, we may contact you with information about products, services or treatment alternatives directly related to your treatment and care.

Sale of Health Information – We will not sell your PHI without your written authorization. If you do authorize such a sale, the authorization will disclose that we will receive compensation for the information that you have authorized us to sell. You have the right to revoke the authorization at any time, which will halt any future sale.

Uses and/or disclosures other than those described in this Notice will be made only with your written authorization. If you do authorize a use and/or disclosure, you have the right to revoke that authorization at any time by submitting a revocation in writing to our Privacy Officer. However, revocation cannot be retroactive and will only impact uses and/or disclosures after the date of revocation.

YOUR RIGHTS

Right to Revoke Authorization – You have the right to revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

Right to Request Restrictions – You have the right to request that we restrict the uses or disclosures of your information for treatment, payment or healthcare operations. You may also request that we limit the information we share about you with a relative or friend of yours. You also have the right to restrict disclosure of information to your commercial health insurance plan regarding services or products that you paid for in full, out-of-pocket and we will abide by that request unless we are legally obligated to do so.

We are not required to agree to any other requested restriction. If we agree, we will follow your request unless the information is needed to a) give you emergency treatment, b) report to the Department of Health and Human Services, or c) the disclosure is described in the "Uses and Disclosures That Are Required or Permitted by Law" section. To request a restriction, you must have your request in writing to the Practice's Privacy Officer. You must tell us a) what information you want to limit, b) whether you want to limit use or disclosure or both and c) to whom you want the limits to apply. Either you or we can terminate restrictions at a later date.

Right to Receive Confidential Communications – You have the right to request that we communicate your PHI in a certain way or at a certain place. For example, you can ask that we only contact you by mail or at work. If you want to request confidential communications you must do so in writing to our Practice's Privacy Officer and explain how or where you can be contacted. You do not need to give us a reason for your request. We will accommodate all reasonable requests.

Right to Inspect and Copy – You have the right to inspect and request copies of your information. I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Benningfield Chiropractic Clinic to save these electronically for me and not print them out after each visit. I understand that, upon request, these reports are available to be printed or emailed to me for review.

To inspect or copy your information, you may either complete an Authorization to Release/Obtain Information form or write a letter of request, stating the type of information to be released, the date(s) of service being requested, the purpose of the request, and whether you wish to review the record or receive copies of the requested information in your preferred format. We will abide by your request in the format you have requested, if we are able to do so. If we cannot provide your records to you in the requested format, we will attempt to provide them in an alternative format that you agree to. You may also request that your records be sent to another person that you have designated in writing. Direct this request to the Practice's Privacy Officer. You may be charged a fee for the cost of copying, mailing or other expenses related with your request.

We may deny your request to inspect and copy information in a few limited situations. If you request is denied, you may ask for our decision to be reviewed. The Practice will choose a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

Right to Amend – If you feel that your PHI is incorrect, you have the right to ask us to amend it, for as long as the information is maintained by us. To request an amendment, you must submit your request in writing to the Practice's Privacy Officer. You must provide a reason for the amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information a) was not created by us, unless the person or entity that created the information is no longer available to amend the information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy or d) is accurate and complete.

If your request is granted the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.

Right to an Accounting of Disclosures – You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice's Privacy Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before April 14, 2003.

There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or change your request to avoid or reduce the fee.

Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment or healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.

Right to a Paper Copy of this Notice – You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

Right to File a Complaint – You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows: Robert Benningfield, DC - 2785 Charlotte Hwy 21 Suite 23, Mooresville, NC 28117 - We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation. I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

X Patient Signature: ______________________________ Date ______________

Informed Consent to Treatment

I hereby request and consent to the performance of chiropractic adjustments (also known as spinal manipulations) and other chiropractic procedures, including various modes of physical therapeutic modalities and diagnostic X-rays on me (or on the patient named below, for whom I am legally responsible) by Robert Benningfield, D.C. and/or other licensed doctors of chiropractic who now or in the future work at Benningfield Chiropractic Clinic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand that the type of treatment used in this office is a low force treatment that helps reduce the possibility of the below risks but the information is provided so that I may make an informed decision.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some possible risks to treatment, including but not limited to 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 upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name Printed ______________________ X Patient Signature ______________________

Date ______________________ Parent/Guardian's Signature ______________________

DO NOT WRITE BELOW THIS LINE

Patient Accepted? YES NO Doctor's Signature ______________________