AUTOMOBILE/ACCIDENT QUESTIONNAIRE

Patient Name: ______________________ Date: ______________

VEHICLE YOU WERE IN

Vehicle type?
☐ Car ☐ Pickup ☐ Van ☐ Truck ☐ Station Wagon
☐ Bus ☐ Other ____________

Vehicle size?
☐ Subcompact ☐ Full-Size ☐ Compact ☐ Mini
☐ Mid-Size ☐ Light ☐ Other ________

What was your location in the vehicle?
☐ Driver ☐ Front Passenger ☐ Rear Passenger
Passenger Location: ☐ Left ☐ Middle ☐ Right
☐ Other ____________

What was the vehicle you were in doing?
Mark only one box for the above question
Vehicle stopped for ☐ Traffic Light ☐ Intersection
☐ Stop Sign ☐ Traffic ☐ Pedestrian ☐ Parked
☐ Other ____________

Vehicle slowing down for ☐ Traffic Light ☐ Intersection
☐ Stop Sign ☐ Traffic ☐ Pedestrian ☐ Turning
☐ Parking ☐ Other ____________

Vehicle moving ☐ Slowly ☐ Moderately ☐ Fast
☐ _______MPH ☐ Accelerating
☐ Other ____________

What damage did the vehicle you were in sustain?
☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled
☐ Unsure ☐ Other ____________

IF OTHER VEHICLES INVOLVED IN ACCIDENT

First vehicle to strike vehicle you were in
Vehicle type? ☐ Car ☐ Pickup ☐ Van ☐ Truck
☐ Station Wagon ☐ Bus ☐ Other ________

Vehicle size? ☐ Subcompact ☐ Full-Size ☐ Compact
☐ Mini ☐ Mid-Size ☐ Light
☐ Other ____________

How did this vehicle strike the vehicle you were in?
☐ Head On ☐ From Right ☐ From Left
☐ Rear Ended ☐ Sideswiped on Right
☐ Sideswiped on Left
☐ Other ____________

What damage did this vehicle sustain?
☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled
☐ Unsure ☐ Other ____________

Second vehicle to strike the vehicle you were in
Vehicle type? ☐ Car ☐ Pickup ☐ Van ☐ Truck
☐ Station Wagon ☐ Bus ☐ Other ________

Vehicle size? ☐ Subcompact ☐ Full-Size ☐ Compact
☐ Mini ☐ Mid-Size ☐ Light
☐ Other ____________

How did this vehicle strike the vehicle you were in?
☐ Head On ☐ From Right ☐ From Left
☐ Rear Ended ☐ Sideswiped on Right
☐ Sideswiped on Left
☐ Other ____________

What damage did this vehicle sustain?
☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled
☐ Unsure ☐ Other ____________

Describe other vehicles to strike the vehicle you were in
☐ Vehicle Type: ____________
☐ How it struck: ____________
☐ Vehicle Size: ____________
☐ Damage: ____________

Were traffic citations issued as a result of the accident?
☐ No citations issued ☐ Driver of other vehicle
☐ Driver of vehicle you were in ☐ You
☐ Unsure

AT MOMENT OF IMPACT

Were you prepared for the accident?
☐ Accident was a complete surprise
☐ Aware of impending collision
☐ Braced for impact

Was your foot on the brake pedal at impact?
☐ Yes ☐ No

Were you wearing a restraint belt?
☐ Yes ☐ No

What type of restraint belt were you wearing?
☐ Shoulder-Lap Belt ☐ Shoulder Belt ☐ Lap Belt

Was your vehicle equipped with air bags?
☐ Yes ☐ No ☐ Unsure

Questionnaire for Personal Injury

Patient's Name ______________________________ Date of the Accident: ______________

Do you have an attorney (please circle: YES / NO)? If yes,

What is your attorney's name? ______________________________ Phone #: ___________

Address: ______________________________ City: ___________ State: _____ Zip: _____

Were there witnesses to the accident (please circle: YES / NO)? If yes,

Name(s) of witnesses: ______________________________ Phone #: ______________

______________________________ Phone #: ______________

Auto Insurance Information:

1. The vehicle in which you were riding:

   Owner: ____________________

   Ins. Co. Name: ____________________ Policy #: ____________________

   Ins. Co. Agent: ____________________ Agent Phone #: ______________

   Ins. Co. Adjustor: __________________ Adjustor Phone #: __________ Claim #: __________

2. Your vehicle (if different than above):

   Owner: ____________________

   Ins. Co. Name: ____________________ Policy #: ____________________

   Ins. Co. Agent: ____________________ Agent Phone #: ______________

   Ins. Co. Adjustor: __________________ Adjustor Phone #: __________ Claim #: __________

3. Vehicle that hit the car in which you were riding:

   Owner: ____________________

   Ins. Co. Name: ____________________ Policy #: ____________________

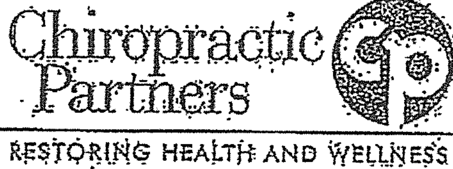
   Ins. Co. Agent: ____________________ Agent Phone #: ______________

   Ins. Co. Adjustor: __________________ Adjustor Phone #: __________ Claim #: __________

4. Was a violation citation issued (please circle: YES / NO)?

   _____ To driver of other vehicle _____ To driver of your vehicle

5. Were you (please circle: DRIVING / A PASSENGER)?



Michael Krasnov, D.C., C.C.S.P.
3319 Durham Chapel Hill Blvd.
Durham, NC 27707
(P)919-383-9890

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 Dr. Michael Krasnov to treat me on credit without demand for payment at the time of services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to Dr. Michael Krasnov 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 Dr. Michael Krasnov, from any disability benefits, medical payments 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 or may become due to Dr. Michael Krasnov for his services rendered.

I appoint Dr. Michael Krasnov as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am named payee and which was issued in payment of services received by Dr. Michael Krasnov, and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Dr. Michael Krasnov.

I authorize Dr. Michael Krasnov 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 Dr. Michael Krasnov for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If Dr. Michael Krasnov is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Dr. Michael Krasnov for his costs of recovery, including reasonable attorney's fees.

______________________________ ______________________

Patient Date

____

Witness

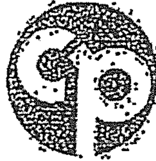
Notice of Lien

Pursuant to NCGS 44-49 and 44-50, Dr. Michael Krasnov 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.

Dr. Michael Krasnov hereby requests that if his claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with NCGS 44-50.1. Dr. Michael Krasnov agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

Chiropractic Partners



RESTORING HEALTH AND WELLNESS

Michael Krasnov, D.C., C.C.S.P.
3319 Durham Chapel Hill Blvd.
Durham, NC 27707
(P)919-383-9890

Doctor's Lien

Ref: ______________________

Claim #: ______________________

Date: ______________

From: Dr. Michael Krasnov
3319 Durham Chapel Hill Blvd
Durham, NC 27707

I do, hereby give a lien to above doctor on any settlement, claim, judgment, or verdict as a result of my accident/illness which occurred on ____________. I authorize and direct you to pay directly to said doctor any/all sums that may be due for any/all services rendered to me. I authorize you to withhold such sums from any settlement, claim, judgment, or verdict, and to protect said doctor adequately. I understand that I am directly and fully responsible to said doctor for any/all services billed by him for services rendered to me, and that this agreement is made to further protect the doctor's reimbursement of services rendered, and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, claim, or verdict that I may eventually recover. This lien shall be irrevocable, until such time that all of the doctor's bills have been paid in full.

Patient's Name ______________________ Date ______________

Patient's Signature ______________________

Witness ______________________

Confirmation of Receipt and Compliance

The undersigned, being the attorney of record or an authorized representative of insurance carrier, for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor this lien to protect the above named doctor, as detailed: Pursuant to NCGS.44-49 and 44-50.

Name of Authorized Representative ______________________

Authorized Signature ______________________ Date: ______________

Please sign, date, and return original copy to the doctor's office at address shown above. Please make a copy for your records.

Chiropractic Partners

Personal Injury Checklist

_______Office Completed the PI/WC Excel for CARE (excel form)

_______Patient Completed the Irrevocable Assignment of Benefits (mandatory)

_______Patient Completed the Notice of Auto Accident (mandatory)

_______ Patient Understands their Health Insurance May/May Not be billed: See *Personal Injury Health Insurance Non-Submission Form*

_______Patient Completed the *Personal Injury Questionnaire Form (Internal Office Forms)*

_______ Patients Information was properly put into Eclipse
-Condition Tab
-Date of Accident
-Insurance Information Entered
-Claim number Entered

_______ Faxed PI Packet to CARE to initiate PI Claim within 2 days from initial treatment

Work Comp Checklist

_______Office Completed the PI/WC Excel for CARE (excel form)

_______Office has obtained written authorization of treatment (recommended in writing with specific CPT codes)

_______ Patients Information was properly put into Eclipse
-Condition Tab
-Date of Accident
-Batch Claims Only
-Insurance Information Entered
-Claim number Entered

_______Faxed WC Packet to CARE to initiate WC Claim within 2 days from initial treatment

*Any additional questions call CARE at 540-635-7777

*Fax All Information to CARE at 540-635-3761

Chiropractic Partners

Personal Injury: Healthcare Insurance Non-Submission Form

I have requested that __**Chiropractic Partners**__ will **NOT** submit my personal injury claims to my healthcare insurance company. I am aware that __ **Chiropractic Partners** __is an in network provider for my healthcare insurance company, but have declined this office from submitting my claims to my healthcare insurance company. I understand that there is timely filing rules with my health insurance company which is ______________________ and currently is an effective policy. It is my right to make this decision and forego giving this personal health information (PHI)to my healthcare insurance company in conjuction with HIPAA guidelines.

If I choose to have __**Chiropractic Partners** _submit my claims to my healthcare insurance company listed above, I will submit this **in writing** to their office prior to the timely filing limits of my insurance company. If I do not submit in writing to ___ **Chiropractic Partners** _within the timely filing limit of ____________________ days, I will not have an opportunity to file with the insurance company. _**Chiropractic Partners**_ requires I give an additional two weeks notice for any change in the above to make sure the claims are submitted within the timely filing and adhere to the necessary claim processing time that is needed in our office.

By signing below I understand the above and if I have any additional questions, I realize I may call my health insurance company or attorney for further guidance.

Patient Signature_____________________________________ Date:_____________

© CARE Medical Billing, Inc. 2013

Date:	**OFFICE:**			
Initials:	**PI PATIENT INFORMATION**			
LAST NAME				
FIRST NAME				
DATE OF BIRTH				
DATE OF ACCIDENT				
REPRESENTING LAW FIRM				
CASE MANAGER				
PHONE NUMBER				
AUTO INSURANCE				
POLICY NUMBER				
CLAIM NUMBER				
ADJUSTER				
PHONE NUMBER				
HEALTH INS. (IF BILL-ABLE FOR PI)				
POLICY NUMBER				
GROUP NUMBER				
PHONE NUMBER				
ANY ADDITIONAL BILLABLE INSURANCE INFORMATION (IF BILL-ABLE FOR PI)				
CARE WILL COMPLETE	DATE:	INITIALS:	SPOKE TO:	
CLAIM# VERIFIED	CIRCLE	YES	NO	Claim number:
ACTIVE CLAIM	CIRCLE	YES	NO	
PI BENEFITS				
FAX CLAIMS TO				
MAIL CLAIMS TO				
ADJUSTER				
ADJUSTER #				

Please include PI checklist information