

Auto Accident Details

Patient Name _____

Today's Date ____/____/____

Please mark your involvement in the Auto Accident: Pedestrian Driver Passenger

What are your current symptoms? Pain Numbness Stiffness Weakness

Date of Accident ____/____/____

Patient was located: Driver Passenger- middle front Passenger- right front
 Passenger- left rear Passenger- middle rear Passenger -right rear

Patient Vehicle Type: Compact Mid-size Full-Size SUV Pick-up Motorcycle

Second Vehicle Type: Compact Mid-size Full-Size SUV Pick-up Motorcycle

Third Vehicle Type: Compact Mid-size Full-Size SUV Pick-up Motorcycle

Road Conditions: Clear Dark Dry Foggy Icy Wet

Road Type: Asphalt Concrete Dirt Gravel

Were you aware the accident was going to occur? Yes No

Were you wearing a seatbelt? Yes No

Did your airbag deploy? Yes No

Does your car have a head rest? Yes No

What position was the head rest in? Up Middle Down

Patient's Head Position: Looking Straight Ahead Left Level Left Up Left Down
 Right Level Right Up Right Down Looking Up Looking Down

Accident Details

Was your car braking? Yes No Was your car moving? Yes No
If yes, how fast? (mph) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

Was the second vehicle braking? Yes No Was the second vehicle moving? Yes No
If yes, how fast? (mph) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

Was the third vehicle braking? Yes No Was the third vehicle moving? Yes No
If yes, how fast? (mph) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

Collision Details

First Impact: hit by other vehicle hit other vehicle hit by object hit object
Impact Location: front front-right front-left left
 right right-rear left-rear rear top

Second Impact: hit by other vehicle hit other vehicle hit by object hit object
Impact Location: front front-right front-left left
 right right-rear left-rear rear top

Collision Results

Body was thrown: Forward Backward Left Right Can't Remember

Head Hit: airbag front windshield rearview mirror steering wheel
 dashboard back of the front seat side window/door another person's body headrest

Chest Hit: airbag steering wheel dashboard back of the front seat
 side window/door another person's body

Shoulders Hit: shoulder harness side window/door back of front seat another person's body

Knees Hit: steering wheel dashboard back of the front seat
 door panel center console another person's body

Hips Hit: steering wheel dashboard back of the front seat
 door panel center console another person's body

Vehicle Damage

Patient Vehicle: totaled significant damage light damage no damage
Second Vehicle: totaled significant damage light damage no damage
Third Vehicle: totaled significant damage light damage no damage

Hospitalized

Were you hospitalized? Yes No. If yes, please answer the questions below.

When were you hospitalized? immediately later same day next day date _____

How were you transported to the hospital? ambulance life flight private transportation

What did the hospital recommend? no instructions see this clinic see DC
 see own doctor see orthopedist see neurologist prescription medication
 other: _____

Did you have any xrays taken? Yes No
If yes, what areas? _____

Assignment of Benefits

Patient Name: _____

Insurance Carrier: _____

Claim #: _____

I hereby assign all medical benefits to which I am entitled to Yost Family Chiropractic, Inc. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment check(s) directly to Yost Family Chiropractic, Inc, for services rendered for myself and/or my dependents.

I understand that I will utilize my own auto insurance carrier for payment/benefits, regardless to who is at fault. My auto insurance will be responsible for collecting reimbursement from the at-fault party's insurance carrier.

I understand that it is my responsibility to report any changes in insurance coverage.

I authorize the release of any medical or pertinent information necessary to obtain these benefits to my insurance carrier, or any other medical entity for continued medical care.

I understand that I am financially responsible for any amount not covered by my insurance. I agree to be responsible for all costs with collection and/or attorney fees if my account is left unpaid.

Print Patient/Guardian Name: _____

Patient/Guardian Signature: _____

Date: _____

Witness: _____ **Date:** _____

Using Health Insurance?

Follow the simple steps below before your first visit in our office. It's as easy as 1, 2, 3! Ask your insurance representative any additional questions you may have.

1. Call the Customer Service/Member # on your insurance card. Follow the automated steps to receive your member benefits.
2. What is Insurance Representatives name: _____
 - a. Date: _____ Time: _____
3. My name is _____; I am calling to see what my chiropractic benefits are.
4. I will be seeing Dr. Heather Yost with Yost Family Chiropractic. Is she in or out of network?
5. Is there a deductible? {YES} {NO} (circle one)
 - a. If YES, what is my deductible amount? _____
 - b. How much has been applied to my deductible? _____
6. What are my chiropractic benefits?
 - a. Co-Insurance: _____
 - b. Copay: _____
7. Are there any policy limitations such as a dollar amount or number of office visits?

 - a. If YES, has anything been already applied to these limitations? _____
8. What is my policy period? (example: calendar year) _____
9. Is authorization and/or referral required for my plan? _____
10. Are my covered benefits based on medical necessity? {YES} {NO} (circle one)
11. Provide your insurance representative with the following codes. Find out if they have the same chiropractic benefit quoted above or if they have a separate benefit.
 - a. Are x-rays covered, if done in the office? _____
 - b. CPT Code 99202 (Exam): _____
 - c. CPT Code 97014 (Muscle Stimulation Therapy): _____
 - d. CPT Code 97112 (ART, Muscle Therapy): _____
 - e. CPT Code 29200 (Kinesotape Strapping): _____

Consultations are free of charge and all fees will be discussed before any services are rendered

PS – Have an HSA or FLEX account? Great news! Take advantage of reduced fees (sometimes even better than your insurance benefits!) by using these tax savings accounts!

Patient Print Name: _____ Patient Sign: _____ Date: _____