MOTOR VEHICLE COLLISION QUESTIONAIRE

Please answer all questions completely:

Patients Name: _____

Address: _____

City, State Zip: _____

SSN: _____ Date of Birth: _____

Gender: Male Female Marital status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Home Number: _____ Work Number: _____

Cell Phone: _____ Email Address: _____

Occupation _____ Employer _____

What are your job requirements? _____

Who were you referred by? _____

What is your major complaint? _____

Collision History

1. Date of collision: _____ Time: _____ AM / PM
2. Please describe **IN DETAIL** the collision in your own words:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

3. Where did the collision occur? City: _____ State: _____
4. Were you the: ☐ driver ☐ passenger ☐ pedestrian

   If passenger, were you in the ☐ front seat ☐ behind the front passenger ☐ behind the driver
5. How many passengers in your vehicle? _____

6. In which direction were you traveling: North South East West

   On what street were you traveling? _____

   What directions was the other vehicle traveling? North South East West

   On what street was the other vehicle traveling? _____

7. What was the approximate speed at the time of the impact?

   Your vehicle _____ mph other vehicle _____ mph

8. Was your vehicle in: ☐ park ☐ moving ☐ stopped

9. Was the impact to your vehicle from:

   ☐ the front ☐ the rear ☐ the driver side ☐ the passenger side

10. Was your vehicle shoved: ☐ forward ☐ backward ☐ sideways ☐ other: ____

11. Did the vehicle go into a spin or roll as a result of the impact? ☐ yes ☐ no

    If yes, please explain: _____

    _____

12. Did you airbag deploy? ☐ yes ☐ no

13. Was your vehicle ☐ Towed or ☐ Driven from accident scene?

14. Was there any glass from your vehicle broken? ☐ yes ☐ no

    Which window(s): _____

15. How many vehicles were involved? 1 2 3 4 5 Other: _____

16. Were the police on the scene? ☐ yes ☐ no

    If yes was there a police report taken? ☐ yes ☐ no

    If yes please make sure that a copy is retrained by the office for your file.

Vehicle

17. What type of vehicle were you in? _____

    What type was the other vehicle? _____

18. How much damage was there to the **outside** of the vehicle?

    ☐ none ☐ some ☐ a lot

    Patient's vehicle: Please explain: _____

    Cost of damage: _____

    Other party: Please explain: _____

    Cost of damage: _____

19. How much damage was there to the **inside** of the vehicle?

    ☐ none ☐ some ☐ a lot

Patient's vehicle: Please explain: _____

Cost of damage: _____

Other party: Please explain: _____

Cost of damage: _____

20. Did your seat have a head restraint (headrest)? ☐ yes ☐ no

    If yes, what was the position: ☐ low ☐ mid position ☐ high

    Did your head ride over the headrest? ☐ yes ☐ no

21. Were you wearing your seat belt? ☐ yes ☐ no

    Did the belt have a shoulder harness? ☐ yes ☐ no

    If yes, did it contribute to the pain you are experiencing now? ☐ yes ☐ no

22. Is your vehicle equipped with an air bag? ☐ yes ☐ no

    Did the air bag deploy? ☐ yes ☐ no

    If yes, did it contribute to the pain you are experiencing now? ☐ yes ☐ no

23. What was the weather at the time of the collision? ☐ dry ☐ wet ☐ icy

    What was the visibility? ☐ clear ☐ foggy ☐ other: _____

    What time of day did the accident occur?

    ☐ morning (bright & sunny) ☐ mid-day (sunny) ☐ late afternoon (sun going down) ☐ evening (dark)

    Where your headlight on/off? ☐ ON ☐ OFF

Injury Details

24. Were you surprised by the impact? ☐ yes ☐ no
25. Were your brakes being applied? ☐ yes ☐ no
26. Were you braced for the impact? ☐ yes ☐ no
27. Were you holding onto the steering wheel? ☐ yes ☐ no
28. Did you brace your legs against the floorboard? ☐ yes ☐ no
29. Was your ankle turned? ☐ yes ☐ no
30. Were you shoved: ☐ yes ☐ forward ☐ whipped backwards ☐ other: _____
31. Did your hat/glasses end up in the back seat or rear window? ☐ yes ☐ no
32. Did the seat break as a result of the impact? ☐ yes ☐ no
33. Did any other part of your body hit the interior of the vehicle? ☐ yes ☐ no

    If yes, please specify body part and part of the interior: (i.e., head hit windshield)

    _____

    _____

34. At the time of impact were you:

☐ looking straight ahead ☐ right/left (circle one) ☐ down/up (circle one)

Symptoms

35. Immediately after the accident were you: ☐ conscious ☐ dazed ☐ unconscious

If you lost consciousness, how long? _____

36. At the point of impact, were did you experience pain? Be specific:

_____

_____

Please List **ONE BODY PART** per complaint.

37. **Complaint #1**:

What is your major complaint? _____

When did your symptoms begin: ☐ immediately ☐ hrs/days/weeks after

What percentage of the time do you experience/feel this symptom? _____%

What activities make this symptom worse? _____

What makes this symptom better? _____

Can/Do you have this symptom without activity? _____

Pain Scale (circle): Mild Moderate Severe

Has this condition: ☐ Improved ☐ Unchanged ☐ Getting Worse

Is this condition interfering with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Excercise

38. Complaint #2:

What is your major complaint? _____

When did your symptoms begin: ☐ immediately ☐ hrs/days/weeks after

What percentage of the time do you experience/feel this symptom? _____%

What activities make this symptom worse? _____

What makes this symptom better? _____

Can/Do you have this symptom without activity? _____

Pain Scale (circle): Mild Moderate Severe

Has this condition: ☐ Improved ☐ Unchanged ☐ Getting Worse

Is this condition interfering with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Excercise

39. Complaint #3:

What is your major complaint? _____

When did your symptoms begin: ☐ immediately ☐ hrs/days/weeks after

What percentage of the time do you experience/feel this symptom? _____%

What activities make this symptom worse? _____

What makes this symptom better? _____

Can/Do you have this symptom without activity? _____

Pain Scale (circle): Mild Moderate Severe

Has this condition: ☐ Improved ☐ Unchanged ☐ Getting Worse

Is this condition interfering with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Excercise

If you are experiencing additional complaints please list on the back.

40. Have you lost any days of work from this injury? ☐ yes ☐ no Dates:_____

If yes, explain: _____

_____

Treatment Received

Please list ALL doctors you have seen regarding this accident. Please List them in chronological order/the order you saw them in:

41. Did you go to the **Hospital**? ☐ yes ☐ no

If yes, when? ☐ right after the injury occurred ☐ next day ☐ other: _____

If yes, how did you get there? (i.e., ambulance, drove) other: _____

If by ambulance, did the ambulance attendants place you in a: ☐ neck brace

☐ back brace ☐ other _____

Did the ambulance administer any medication or medical supplies?

_____

Name of hospital: _____

Name of doctor: _____

Diagnosis: _____

Treatment Received: _____

Were any medications prescribed? _____

Did you have x-rays taken at the hospital? ☐ yes ☐ no

Did you have an MRI at the hospital? ☐ yes ☐ no

42. **Name of Doctor/Facility #1**: _____ City/Location: _____

Type of Doctor (degree or specialty): _____

Describe the treatment and/or tests received: _____

_____

What did this doctor say was wrong with you? _____

_____

Date when treatment started: _____ Date when treatment stopped: _____

How many treatments/visits were there? ____ How long were the treatments? _____

What was the result/outcome of the treatment? _____

_____

Still Treating with this doctor? ___ Yes ___ No If "Yes", how often? _____

43. **Name of Doctor/Facility #2**: _____ City/Location: _____

Type of Doctor (degree or specialty): _____

Describe the treatment and/or tests received: _____

_____

What did this doctor say was wrong with you? _____

_____

Date when treatment started: _____ Date when treatment stopped: _____

How many treatments/visits were there? ____ How long were the treatments? _____

What was the result/outcome of the treatment? _____

_____

Still Treating with this doctor? ___ Yes ___ No If "Yes", how often? _____

If you sought any additional treatment please list the physician(s)'s information on the back.

Patient History

44. Have you had any similar problems before? ☐ yes ☐ no
45. Medications, dosage, frequency and reason: _____

_____

46. List surgical operations and years: _____

_____

47. Are you diabetic? ☐ yes ☐ no
48. Do you have high blood pressure? ☐ yes ☐ no
49. Do you have low blood pressure? ☐ yes ☐ no

50. Do you have arthritis or degenerative joint disease? ☐ yes ☐ no

51. Prior sports related injuries: _____

_____

52. Prior motor vehicle crashes: _____

_____

53. Prior work related injuries: _____

_____

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. The policy reduces your out-of-pocket expense and allows you to place your family under care.

1. If You Do Not Have Insurance: All payments are expected at the time of service or by an authorized payment plan. 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 Have Insurance: I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of Unruh Chiropractic, Inc. or Thrive Medical, Inc. I assign and authorize payments to Unruh Chiropractic, Inc. or Thrive Medical, Inc. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law.

All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

Insurance figures are **ESTIMATES ONLY!** It is not easy for an office to become familiar with the exact details of every Insurance Plan it encounters. **It is the responsibility of the patient, NOT the doctors' office to know what is covered and what is excluded from their particular Insurance Plan.**

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. **We DO NOT accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.**

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 arbitrary schedule of fees bearing no relationship to the current standard of care in this area. **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 within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance.

As the patient you agree that you are seeking care under your accord if your insurance denies your care for any reason, including but not limited to medical necessity, timely filing, etc.

Cancellation Fee: We do not over-book our physician's schedules. We want every patient to be able to receive the care that they need. Therefore, when you cancel or do not show up to your appointment you are preventing someone else from getting the care they need.

If you do not cancel your appointment within 4 hours of your scheduled time or if you do not show up to your appointment you will be charge a **$25 cancellation fee** due on your next date of service.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Printed Name of Patient or Guardian Relationship to Patient

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

_____ _____

Patient's Name (Print) Patient's Signature

_____ _____

Date Relationship or authority if not signed By patient

_____

Witness

Insurance Information

Date of Accident: _____

Patient: _____

Patient's Health Insurance

Insurance Company: _____

Policy Number: _____

Claim Number: _____

Adjuster Name: _____ Phone: _____

Address: _____

Patient's Auto Insurance

Insurance Company: _____

Policy Number: _____

Claim Number: _____

Adjuster Name: _____ Phone: _____

Address: _____

Med Pay? _____

Other Parties Auto Insurance

Insurance Company: _____

Policy Number: _____

Claim Number: _____

Adjuster Name: _____ Phone: _____

Address: _____

Patient's Attorney

Name: _____ Phone: _____

Address: _____

Patient Signature _____ Date _____

Parent/Guardian _____ Date _____

Print Name _____

PATIENT RECORDS AND DOCTOR'S LIEN

TO: ATTORNEY/INSURANCE CARRIER

_____
_____
_____
_____

Provider:
Unruh Chiropractic, Inc.
23043 Lyons Avenue
Santa Clarita, CA 91321
(661) 288-0022

I do hereby authorize the above provider to furnish you, my attorney/insurance carrier, with a full report of his/her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my injury/illness which occurred/began on: _____

I hereby give a lien to said provider on any settlement, judgment, or verdict as a result of said injury/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said provider such sums as may be due and owing him/her for services rendered me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect said provider adequately.

I fully understand that I am directly and fully responsible to said provider for all bills submitted by him/her for service rendered me, and that this agreement is made solely for said provider's additional protection and in consideration of his/her awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee. _____

I agree that if my injuries are the result of a third party liability the third party is responsible for my bills and my personal health insurance cannot be billed. I agree and understand that if my case is not paid by the resolution of my injury/illness case then my personal health insurance may be billed. I understand that I am responsible for any balance in full not allowed/covered by my personal health insurance. _____

I fully understand that payment to provider is due three years from the date of injury/illness regardless of the resolution/status of my case. _____

I further agree to be fully responsible for reasonable attorney's fees and costs that have accrued due to the pursuance of payment of my account. Also, that in the event of noncompliance to payment agreement I understand the amount of balance due will be subject to a 1% per month service charge.

I further agree to inform said provider of any change in my attorney representation by sending written notice to said provider of the name, address and telephone of the new attorney representation or that I am handling the case on my own. I also agree that I am responsible for having my attorney sign this lien within 30 days of acquiring new representation. _____

I also agree to inform said provider within 15 days of any resolution of the case by settlement, verdict, or arbitration. _____

Patient's Signature: _____ Dated: _____

Patient's Name (print): _____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately the above named provider.

Attorney further agrees to inform said provider of any change in patient's attorney representation by sending written notice to said provider of the name, address and telephone of the new attorney representation or that the patient is handling the case in prop per. Attorney also agrees to inform said provider within 15 days of any resolution of the case by settlement, verdict, arbitration or award or that the case is no longer being pursued by the patient.

Attorney's Signature: _____ Dated: _____

Please sign, retain a copy for your records, and return this copy to us promptly.

PATIENT RECORDS AND DOCTOR'S LIEN

TO: ATTORNEY/INSURANCE CARRIER

_____
_____
_____
_____

Provider:
Unruh Medical, Inc
23043 Lyons Avenue
Santa Clarita, CA 91321
(661) 288-0022

I do hereby authorize the above provider to furnish you, my attorney/insurance carrier, with a full report of his/her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my injury/illness which occurred/began on: _____

I hereby give a lien to said provider on any settlement, judgment, or verdict as a result of said injury/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said provider such sums as may be due and owing him/her for services rendered me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect said provider adequately.

I fully understand that I am directly and fully responsible to said provider for all bills submitted by him/her for service rendered me, and that this agreement is made solely for said provider's additional protection and in consideration of his/her awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee. _____

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I further agree to inform said provider of any change in my attorney representation by sending written notice to said provider of the name, address and telephone of the new attorney representation or that I am handling the case on my own. I also agree that I am responsible for having my attorney sign this lien within 30 days of acquiring new representation. _____

I also agree to inform said provider within 15 days of any resolution of the case by settlement, verdict, or arbitration. _____

Patient's Signature: _____ Dated: _____

Patient's Name (print): _____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately the above named provider.

Attorney further agrees to inform said provider of any change in patient's attorney representation by sending written notice to said provider of the name, address and telephone of the new attorney representation or that the patient is handling the case in prop per. Attorney also agrees to inform said provider within 15 days of any resolution of the case by settlement, verdict, arbitration or award or that the case is no longer being pursued by the patient.

Attorney's Signature: _____ Dated: _____

Please sign, retain a copy for your records, and return this copy to us promptly.

PATIENT RECORDS AND DOCTOR'S LIEN

TO: ATTORNEY/INSURANCE CARRIER

_____
_____
_____
_____

Provider:
A. Young Kim, Ph. D, L.Ac
23043 Lyons Avenue
Santa Clarita, CA 91321
(661) 288-0022

I do hereby authorize the above provider to furnish you, my attorney/insurance carrier, with a full report of his/her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my injury/illness which occurred/began on: _____

I hereby give a lien to said provider on any settlement, judgment, or verdict as a result of said injury/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said provider such sums as may be due and owing him/her for services rendered me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect said provider adequately.

I fully understand that I am directly and fully responsible to said provider for all bills submitted by him/her for service rendered me, and that this agreement is made solely for said provider's additional protection and in consideration of his/her awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee. _____

I agree that if my injuries are the result of a third party liability the third party is responsible for my bills and my personal health insurance cannot be billed. I agree and understand that if my case is not paid by the resolution of my injury/illness case then my personal health insurance may be billed. I understand that I am responsible for any balance in full not allowed/covered by my personal health insurance. _____

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I further agree to inform said provider of any change in my attorney representation by sending written notice to said provider of the name, address and telephone of the new attorney representation or that I am handling the case on my own. I also agree that I am responsible for having my attorney sign this lien within 30 days of acquiring new representation. _____

I also agree to inform said provider within 15 days of any resolution of the case by settlement, verdict, or arbitration. _____

Patient's Signature: _____ Dated: _____

Patient's Name (print): _____

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Attorney's Signature: _____ Dated: _____

Please sign, retain a copy for your records, and return this copy to us promptly.