Automobile Accident Questionnaire

Please answer all questions completely

Name_____ Sex_____ Marital Status_____ Date Of Birth_____

Home Phone_____ Work Phone_____

Address_____ City_____ State_____ Zip_____

Social Security #_____ Occupation_____

Company Name & Address_____

Spouse's Name_____ Employer_____

Who referred you to our office?_____

Date Of Accident_____

Please explain in detail how your accident happened_____

_____

Driver of vehicle in which you were injured_____

Insurance Company_____ Phone #_____

Policy No._____

Claim No._____

Driver of other vehicle_____

Their Insurance Company_____

Policy No._____

Claim No._____

Name of your insurance adjustor_____

Have you retained an attorney? YES NO

If so, his name and address_____

Patient Name_____

You were heading: NORTH SOUTH EAST WEST on_____
(street or highway)

Other vehicle was headed: NORTH SOUTH EAST WEST on_____
(street or highway)

Were the police notified? YES NO

Were you knocked unconscious? YES NO if YES, for how long?_____

You were struck from BEHIND FRONT LEFT SIDE RIGHT SIDE

You were DRIVER PASSENGER FRONT SEAT BACK SEAT USING SEAT BELT

Time and Date of injury_____

Did you feel pain immediately after the accident? YES NO

If YES, where?_____

Where you taken after the accident?_____

What treatment was given?_____

Was any other doctor consulted after your accident? YES NO

If YES, what was the doctors name?_____

What was the diagnosis_____

What treatment was given?_____

How often did you see the doctor?_____

Have you ever had complaints in the involved area before? YES NO

If so, what were the complaints?_____

Before the injury, were you capable of working on an equal basis with others your age? YES NO

Are your work activities restricted as a result of this accident? YES NO

Since this injury are your symptoms IMPROVING GETTING WORSE SAME

HEALTH QUESTIONNAIRE:

Please indicate any of the following symptoms you have experienced since the accident.

MUSCULO-SKELETAL

_____Low Back Problems
_____ Pain Between Shoulders
_____Neck Problems
_____Arm Problems
_____Leg Problems
_____Swollen Joints
_____Painful Joints
_____Stiff Joints
_____Sore Muscles
_____Weak Muscles
_____Walking Problems
_____Broken Bones

GENITO-URINARY

_____Bladder Trouble
_____Excessive Urination
_____Scanty Urination
_____Painful Urination
_____Discolored Urine

FEMALE

_____Vaginal Discharge
_____Vaginal Bleeding
_____Vaginal Pain
_____Breast Pain
Are you pregnant?
____Yes ____No

GASTRO-INTESTINAL

_____Poor Appetite
_____Excessive Hunger
_____Difficulty Chewing
_____Difficulty Swallowing
_____Excessive Thirst
_____Nausea
_____Vomiting Food
_____Vomiting Blood
_____Abdominal Pain
_____Diarrhea
_____Constipation
_____Bloody Stool

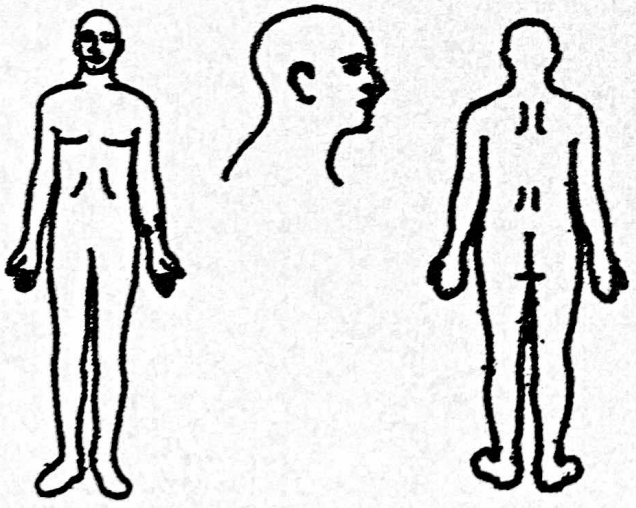
CARDIO-VASCULAR

_____Chest Pain
_____Pain Over Heart
_____Difficulty Breathing
_____Persistent Cough
_____Coughing Phlegm
_____Coughing Blood
_____Rapid Heartbeat
_____High Blood Pressure
_____Heart Problems
_____Lung Problems
_____Varicose Veins

EYE, EAR, NOSE And THROAT

_____Eye Strain
_____Eye Inflammation
_____Vision Problem
_____Ear Pain
_____Ear Noise
_____Ear Discharge
_____Hearing Loss
_____Nose Pain
_____Nose Bleeding
_____Nose Discharge
_____Difficult Breathing thru nose
_____Sore Gums
_____Dental Problems
_____Sore Mouth
_____Sore Throat
_____Hoarseness
_____Difficult Speech

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW



NERVOUS SYSTEM

_____Numbness
_____Loss of Feeling
_____Paralysis
_____Dizziness
_____Fainting
_____Headaches
_____Muscle Jerking
_____Convulsions
_____Forgetfulness
_____Confusion
_____Depression

_____

Patients Signature

Crosby Chiropractic Center
P.O. Box 1565
Crosby, Texas 77532
(281) 328-5544

Date_____

Patient:_____

Employer:_____

Claim Number:_____

SS# / ID:_____

I hereby instruct and direct _____**Insurance Company to pay by check made out to and mailed to:**

Crosby Chiropractic Center
P.O. Box 1565
Crosby, TX 77532

Or

If my current policy prohibits direct payment to doctor, I hereby instruct and direct you to make out the check to me and mail it as follows:

Crosby Chiropractic Center
P.O. Box 1565
Crosby, TX 77532

for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at Crosby Chiropractic Center this _____ **day of** _____**, 20**___

_____ _____

Signature of Claimant or Policyholder **Witness**

Crosby Chiropractic Center

ASSIGNMENT OF BENEFITS / CAUSE OF ACTION / PROCEEDS PAID

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, assigns and here now sets over an assignment with an undivided interest in claims, causes of action, and/or other proceeds paid to the doctor/clinic/healthcare provider named above as relates to all calims arising out of an accident which occurred on or about the _____ day of _____, 20____, at or near

_____

Street City State Claim #

and against all responsible parties, their insurance companies and any and all other entities with responsibilities arising there from, and the following rights, and power and authority:

1. **RELEASE OF INFORMATION:** You are authorized to release any information you deem appropriate concerning my physical condition to any insurance companies, attorneys, or adjusters, in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you.

IRREVOCABLE ASSIGNMENT OF RIGHTS & RIGHT OF SUBROGARION: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company, and/or proceeds paid by any insurance company (including, but not limited to any liability insurance, any health insurance, uninsured/underinsured motorist insurance, personal injury protection insurance, medical benefits insurance, and workers' compensation insurance), individual or entity, for benefits or damages to the extent of your bill for total services if such benefits are owed within the terms of the policy, or damages caused by such individual or entity including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court cost, or other legally compensable amounts owed by an insurance company, or individual or entity, in accordance with the common law, the Texas Insurance Code, or other applicable insurance or state statute. I hereby also subrogate my right against all such individuals, entities and insurance companies for benefits or damages to the full extent of your bill for total services. You may take actions as you deem necessary including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court cost, or other legally compensable amounts owed by an insurance company of individual or entity, in accordance with common law, the Texas Insurance Code, or other applicable insurance or state statute. I as the patient and/or responsible party, further agree to cooperate, provide information as needed , and appear as needed, whenever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits or damages of any kind to me/us for treatment rendered by the doctor/clinic/healthcare provider named above, you are hereby tendered demand to pay in full the bill for services rendered by the doctor/clinic/healthcare provider named above within 60days following your receipt of such bill for services to the extent such bills are payable under the terms of our policy or benefits, or for damages or injuries caused by such entity or individual. This demand specifically conforms with this State's Insurance Code, providing for attorney fees, penalty, court costs, and interest from judgment, upon violation. As relates to payment by Insured/Defendant or his/her liability insurance carrier and/or payment of my current policy, I hereby also direct and instruct same to make out checks to me and the doctor/clinic/healthcare provider and mail it as follows:

Payable to: Patient and Crosby Chiropractic Center

Mail to: P.O. Box 1565
Crosby, TX 77532

Third Party Liability: If patient's treatments for injuries are the result of the torts of any third party, then the Patient(s) and/or responsible party grant a lien and assignment of an interest in my/our cause of action against any right of recovery from such third party to the extent of the bills for treatment, in favor of the doctor/clinic/healthcare provider named above. This lien, assignment and all bills protected thereby, are to be paid in full, at the latest, whenever patient and/or responsible party receives and recovery as a result of the aforesaid torts of such third party, whether the recovery is directly from such third party, from any insurance covering such third party, from any insurance covering patient and/.or responsible party (e.g. uninsured/underinsured motorist coverages and personal injury protection / medical payments insurance), or from any other source whatsoever. It is understood and expressly agreed to, that a copy of this assignment may be delivered to the patient and/or other responsible party's attorneys, the third party tortfeasor(s), and their insurance companies, the patient and/or responsible party's insurance companies, and any other person whom the doctor/clinic/healthcare provider named above deems appropriate.

INITIAL_____

STATUTE OF LIMITATIONS: The patient and/or responsible party hereby agrees that any statute of Limitations applicable to any claim of the doctor/clinic/healthcare provider named above shall be tolled form the present until the latter of the final denial of the claim by the Insurance company, final decision in the highest level court the claim may be taken to, or the actual discovery by the doctor/clinic/healthcare provider named above, of the receipt of any recovery by the patient and/or responsible party as a result of the condition being treated hereunder.

ATTORNEYS' FEES, COURT COSTS, INTEREST: The patient and/or responsible party hereby agree that if the doctor/clinic/healthcare provider named above has to resort to any collection efforts in order to enforce this assignment and/or collection of any bills due, in addition to the damages sought, the above named doctor/clinic/healthcare provider shall recover all reasonable costs of collection, including but not limited to attorneys' fees and court cost. Additionally, if collection efforts are required, all bills will then incur interest at the rate of twelve percent (12%) per annum, compounded annually, from thirty (30) days after the date the bill was due, until paid.

UNLIMITED POWER OF ATTORNEY: I hereby grant to the doctor/clinic/healthcare provider named above the power to endorse my name upon any check, draft, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by doctor/clinic/healthcare provider. I agree that my insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my account or forwarded to my address upon request in writing to the doctor/clinic/healthcare provider named above.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL

PRINTED NAME:_____/PARENT_____

SIGNATURE:_____DATE_____

NOTARY_____DATE_____

Crosby Chiropractic Center
5211 FM 2100
Crosby, TX 77532
Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to Chadwick Thornton, D.C., a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits, including any Personal Injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for purposes of processing my claim for benefits and payment for services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court cost, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. A letter of protection issued by an attorney's office will not negate this assignment.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct my carrier to make all checks payable to Crosby Chiropractic Center, and send to P.O. Box 1565 Crosby, TX 77532. I instruct my attorney to provide on request to the above named provider, a settlement breakdown in accordance with the Safekeeping Property Rule, Sec. 1.15.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to Crosby Chiropractic Center, and to send any and all checks to P.O. Box 1565 Crosby, TX 77532.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from ay other doctor, I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

Signature of Patient and/or Responsible Parties:
I declare under penalty of perjury that the forgoing is true and correct. [CPRC: Sec. 132.001(a)]

_____ Date:_____

_____ Date:_____

I _____ hereby acknowledge that I am receiving or about to receive chiropractic health care services at Crosby Chiropractic Center P.C. I have been advised that Crosby Chiropractic Center P.C is willing to wait for payment for the services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim.

I understand that if it is determined either:

1. That there is no insurance company obligated to pay for these services, or if the insurance company involved refuses to acknowledge an assignment to the doctor or the protection of the interest of the doctor;
   or
2. If a liability claim exists, and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney;
   or
3. If the insurance company reduces payment;
   or
4. If the letter of protection from your attorney limits or reduces reimbursement to Crosby Chiropractic Center P.C. for services rendered;

Then, I agree to pay for the services rendered on a current basis. This document will supersede any proposed offer by your attorney or letter of protection and the remaining balance on my account will be my responsibility. My bill will be paid in full as soon as my liability claim is settled or within three months of the date of my last treatment, whichever occurs first.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL

Printed Name_____/Parent_____

Signature:_____Date_____

Notary_____Date_____

Crosby Chiropractic Center

GENERAL CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

If applicable your protected health information will be used by Crosby Chiropractic Center, or disclosed to others, as per our agreement with them, for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of our practice.

You may request a restriction on the use and disclosure of your protected health information. Crosby Chiropractic Center may or may not agree to restrict the use or disclosure of your protected information. If Crosby Chiropractic Center agrees to the request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction may be a violation of the federal privacy standards

.

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date in which you revoke this consent will not be affected.

Crosby Chiropractic Center reserves the right to modify the privacy practices outlined in the notice.

Crosby Chiropractic Center takes every precaution to keep all of my information confidential and that the only times it uses or discloses any of my protected health information, it is done so with the minimal amount necessary to achieve the desired result.

There may be a situation where it may be legally mandated that my information be released to the proper authorities. In this case, I understand that Crosby Chiropractic Center has no choice but to adhere to the legal mandate.

Crosby Chiropractic Center has a policy to advise close family members as to my protected health information. If you do not consent to this check off below asking this office not to do so.

☐ Do not release my information to any family members.

I understand that I am entitled to review my information at any time. I consent that if I request copies of my records, that there may be a reasonable charge for them which I am responsible for.

I have reviewed this consent form and give my permission to Crosby Chiropractic Center to use and disclose my health information in accordance with it.

I request that payment of authorized benefits be made on my behalf to Crosby Chiropractic Center for services furnished to me by the provider.

_____ _____

Signature **Date**

_____

Relationship to Patient

Crosby Chiropractic Center

Informed Consent for Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible) by the doctor(s) and/or anyone working in this office authorized by the doctor(s).

I further understand that such chiropractic services may be performed by the doctor(s) at Crosby Chiropractic Center and /or other licensed Doctors of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Rob Rosenbaum and/or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I understand there is also a risk of increased pain during the healing phase of my care, as my body begins to restore to normal health. I understand that this may be normal and can indicate healing. The risks of not getting my prescribed treatment can include disc and spine degeneration, loss of mobility, loss of function, and loss of muscle tone.
I do not expect the doctor(s) to be able to anticipate and explain all risks and complications. Further I wish to rely on the doctor(s) to exercise judgment during the course of the procedures which the doctor(s) feel are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask question about its contents, and by signing below, I agree to the treatment recommended by the doctor(s). I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

_____

Print Patient's Name

_____

Signature of Patient

_____

____/____/____ Date

To be completed by the patient's representative, if necessary. (ie. If the patient is a minor or is physically incapicated)

_____

Print Name of Representative

_____

Signature of Representative

_____

____/____/____ Date

Doctor's Signature: _____ Date ____/____/____

Crosby Chiropractic Center

Dr. Chad Thornton

Consent for Radiology

I, _____ give the doctor(s) and trained staff assistants of Crosby Chiropractic Center my consent to take any and all x-rays needed to better understand my condition. I acknowledge the inherent radiological risks but also appreciate the regulatory safety standards of state compliance for this office.

I also give my consent for x-rays of my child/children for the same reasons, if applicable.

For Ladies only:
To my best knowledge I am not pregnant and know of no contraindications for x-rays at this time.

Patient Signature:_____ Date:_____

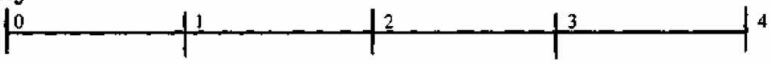
NAME:_____DATE: _____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

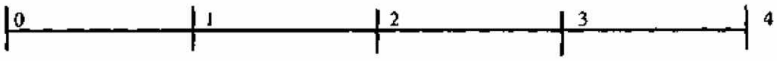
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity



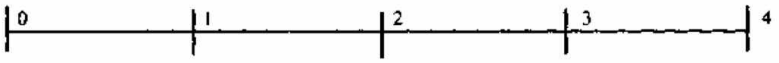
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



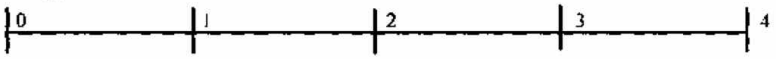
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)



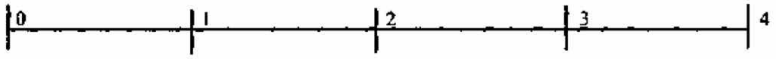
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)



No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

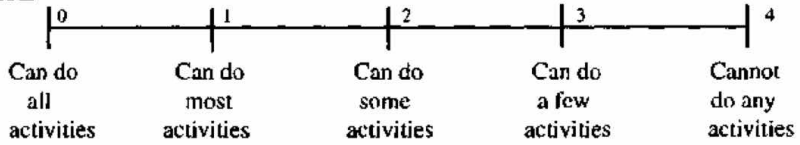
5. Work



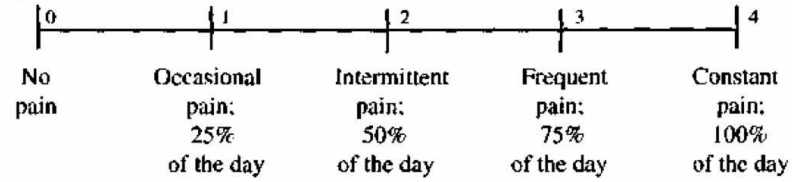
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

Please Turn Over

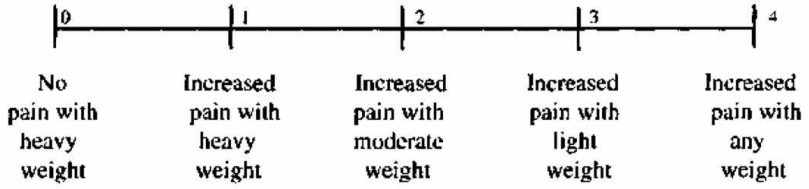
6. Recreation



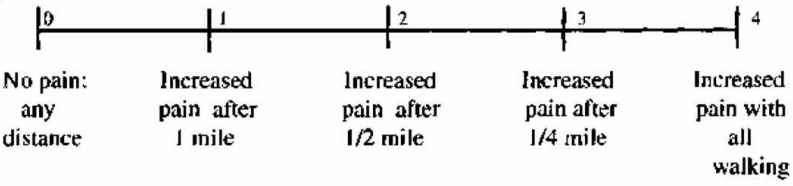
7. Frequency of pain



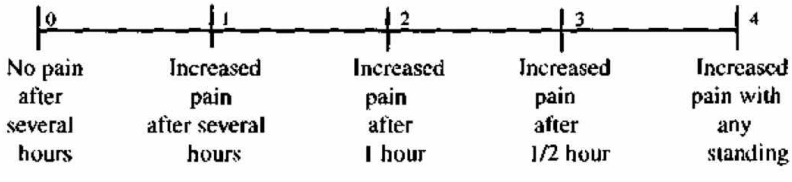
8. Lifting



9. Walking



10. Standing



Patient's Signature **Date**