AUTO COVER SHEET FOR CLAIM INFORMATION

Patient's Full Name: ____

Patient's Street Address: ____

City, State, Zip: ______________________, _______, ____________________

Phone #: (_____) _____ - ___________ Date of Injury: ______/______/_________

Police Report on File? ____ YES _____ NO

INSURANCE TYPES: (check all that apply) ____ P.I.P. ____ Med Pay ____ 3rd Party

____ Attorney ____ Health Insurance ____ Accident/Disability ____ W.C.

****L.O.P. (Letter of Protection) from attorney on file? ____ YES ____ NO**

Have you seen a chiropractor before? ____YES ____ NO Who? ________________

__________ INSURANCE: Name of Ins. Co.: _____________________________
(PIP, Med?)

Phone# of Ins. Co.: (_____) _______ - __________ ext. ________

Address of Ins. Co.: _________________________________

City, State, Zip: ____________________, _____, ____________

Claim #: _______________________ Adjuster: _____________________

__________ INSURANCE: Name of Ins. Co.: _____________________________
(PIP, Med?)

Phone# of Ins. Co.: (_____) _______ - __________ ext. ________

Address of Ins. Co.: _________________________________

City, State, Zip: ____________________, _____, ____________

Claim #: _______________________ Adjuster: _____________________

I, _______________________, agree that any no show/late cancellation fees are my responsibility and are to be paid, by me, prior to seeing Dr. Harper at my next scheduled appointment. _________________________________

(Patient Signature)

INSURANCE COVER SHEET FOR POLICY INFORMATION

Patient's Full Name: ____

Patient's Street Address: ____

City, State, Zip: __________________________, ________, _______________________

Phone #: (_____) _____ - ___________ Date of Injury: ______/______/__________

INSURANCE TYPES: (check all that apply) ____ Primary ____ Secondary ____ Tertiary

____ Accident/Disability

___________ INSURANCE: Name of Ins. Co.: __________________________________
(Primary)

Phone# of Ins. Co.: (_____) _______ - ___________ ext. ________

Address of Ins. Co.: ____

City, State, Zip: _______________________, _____, ______________

Policy #: ___________________________ Group #: _________________________

___________ INSURANCE: Name of Ins. Co.: __________________________________
(Secondary)

Phone# of Ins. Co.: (_____) _______ - ___________ ext. ________

Address of Ins. Co.: ____

City, State, Zip: _______________________, _____, ______________

Policy #: ___________________________ Group #: _________________________

More Info:

>Ins. Co. in Computer? _____ Initials
>Insurance Verified? _____ Initials
>Explained to Patient? _____ Initials
>Info Billed to Ins. Co.? _____ Initials
Co-Pay or % _______________________

Other Notes: ____
____
____

PATIENT NARRATIVE STATEMENT

In your own words and writing, please describe (in detail) the physical, emotional, and mental effects the accident you suffered has had on your work/school and daily living activities:

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Patient Signature: ___________________________________ Date: _____/______/_______

AUTO ACCIDENT FORM (*ALL FIELDS REQUIRE AN ANSWER*)

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 [ ] Looking Up [ ] Looking Down [ ] Left Level
[ ] Left Up [ ] Left Down [ ] Right Level [ ] Right Up [ ] Right Down

Accident Details

Was your car breaking? [ ]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 breaking? [ ]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 breaking? [ ]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 Transport

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 X-Rays Taken? [ ] YES [ ] NO If yes, what areas? ___________________________

Modifying Factors:

Symptoms better with: [ ] Nothing Helps [ ] Activity [ ] Bending [ ] Applying Cold [ ] Rest
[ ] Applying Heat [ ] Massage [ ] Movement [ ] OTC Meds [ ] Rx Meds
[ ] Stretching [ ] Sitting [ ] Standing [ ] Twisting [ ] Walking

Symptoms Worse with: (as noted in Social History)

>**Since condition began, has anything permanently helped you?** [ ] YES [ ] NO

>**Has anything that you have done, thus far, fixed your problem?** [ ] YES [ ] NO

Employment:

Occupation/Job Title: ______________________________________ Work: ______ hrs/ day or week

Description of Work: ____

Job Classification: [ ] Sedentary (<5lbs) [ ] Light (5-20lbs) [ ] Moderate (20-50lbs) [ ] Heavy (>50lbs)

Lifting Frequency: [ ] Constant(67-100%/day) [ ] Frequent(33-66%/day) [ ] Occasional(0-32%/day)

Lifting Postures: [ ] With Arms [ ] High Near [ ] From Knee [ ] Off Posture [ ] From Torso

Work Activity Postures: (hrs/day)
[ ] Bending: ____h/d [ ] Climbing: ____h/d [ ] Kneeling: ____h/d [ ] Pulling: ____h/d [ ] Pushing: ____h/d
[ ] Reaching: ____h/d [ ] Sitting: ____h/d [ ] Standing: ____h/d [ ] Twisting: ____h/d [ ] Walking: ____h/d

Repetitive Activities: (hrs/day)
[ ] Assembly/Fine Manipulation: ____h/d [ ] Computer Use/Typing: ____h/d [ ] Grasping: ____h/d
[ ] Hand Tool Use: ____h/d [ ] Operation of Machinery Controls: ____h/d [ ] Phone Use: ____h/d

Condition's Effect on Job Performance:

[ ] **Mild – Painful** (Can Do) [ ] **Moderate – Painful** (Limited Ability) [ ]**Mod/Sev** Limited Duty
[ ] **Severe –** No Limited Duty [ ] **Severe –** Can't Do Limited Duty

Daily Activities: Effects of Current Condition on Performance:

Bending: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Care – Infirm Family: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Carrying Groceries: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Change Posn-Sit-Stand: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Climb Stairs: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Driving: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Extended Computer Use: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Feeding: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Household Chores: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Kneeling: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Lift Children: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Lifting: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Pet Care: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Reading (Concentration): [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Self Care: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Self Care-Bathing: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Self Care-Dressing: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Self Care-Shaving: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Sexual Activities: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Sleep: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Static Sitting: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Static Standing: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Walking: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
Yard Work: [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance:

______________________ [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
______________________ [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform
______________________ [ ] **No Effect** [ ] **Mild** Painful (can do) [ ] **Mod** Painful (limited) [ ] **Sev** Unable to Perform

Chief Complaint – HPI (History of Present Illness)

Patient Name: ___________________________________ **Date:** ____/____/______ **Dr.:** ______________

Chief Complaint: ____

Body Area(s) Involved: [ ] Cervical [ ] Spine, Ribs, Pelvis [ ] Upper extremity [ ] Lower Extremity

Condition: [ ] New -> [ ] Acute or [ ] Chronic
[ ] Recurrence (Acute) [ ] Exacerbation (Acute) [ ] Chronic

Mechanism of Onset:

[ ] Auto: [ ] Driver/Passenger [ ] Pedestrian (refer to completed auto accident history form)
[ ] Work Related: [ ] Fall [ ] Falling Object [ ] Lifting [ ] Overexertion [ ] Repetitive Motion [ ] Other: _______
[ ] Other – Liability: [ ] Slip or Fall [ ] Other: ____
[ ] Other – No Liability: [ ] Etiology Unknown [ ] Overexertion [ ] Repetitive Use [ ] Slept Wrong [ ] Slip/Fall
[ ] No Injury

Description of Onset of Complaint: ____

Current Symptoms: [ ] Pain [ ] Numbness [ ] Stiffness [ ] Weakness

Location: Left / Right / Bilateral

Quality: [ ] Burning [ ] Diffuse [ ] Dull/Aching [ ]Localized [ ] Radiating [ ] Sharp
[ ] Shooting [ ] Stabbing [ ] Throbbing [ ] Tightness [ ] Tingling [ ] Other: ___________

Level of Impairment Due to Symptoms (Resting):

0 1 2 3 4 5 6 7 8 9 10

Level of Impairment Due to Symptoms (With Activity):

0 1 2 3 4 5 6 7 8 9 10

Duration: Started: ___________________ Last Occurred: ____________________
Last Episode: __________________ Resolved Previous Visit: __________________
Worsened: ___________________ Injury Occurred: _______________ Accident Occurred: ____________

Timing: Worse: [ ] Morning [ ] Afternoon [ ] Night [ ] With Activity [ ] Constant [ ] Intermittent

Context: *Better With:* [ ] Warm Temp [ ] Cold Temp
Worse With: [ ] Warm Temp [ ] Cold Temp [ ] Damp

Assoc Signs & Symptoms: [ ] Blurred Vision [ ] Depression [ ] Dizziness [ ] Irrability/Mood Swing
[ ] Localized Tingling [ ] Nausea [ ] Ringing in Ears [ ] Sleep Disturbance [ ] Stiffness

Headaches: Location: [ ] Occipital [ ] Frontal [ ] Left Temporal [ ] Right Temporal [ ] Sinus [ ] Parietal
Quality: [ ] Dull [ ] Sharp [ ] Throbbing [ ] Stabbing [ ] Aura [ ] No Aura
Types: [ ] Hat Band [ ] Cluster [ ] Migraine [ ] Tension
Other: (frequency/duration/time of day) ____

Radiation: Left / Right / Bilateral ____

Weakness: Left / Right / Bilateral ____

Other Assoc Signs & Symptoms:

[ ] Aches [ ] Burning [ ] Cold Limb(s) [ ] Difficulty Walking [ ] Dizziness
[ ] Eccymosis [ ] Chronic Fatigue [ ] Fever [ ] Heartburn [ ] Joint Stiffness
[ ] Muscle Spasm [ ] Muscle Weakness [ ] Nausea [ ] Numbness [ ] Pale Blush Skin
[ ] Panic [ ] Pins & Needles [ ] Rhinorrhea (runny nose) [ ] Shortness of Breath
[ ] Sweating [ ] Swelling [ ] Tingling [ ] Vomiting

Hill Country Family Chiropractic – Jeffrey Harper, D.C.
1742 FM 2673
Canyon Lake, TX 78133

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 Hill Country Family Chiropractic - Jeffrey Harper, 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 adjustor 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 loss, 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.

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 Hill Country Family Chiropractic – Jeffrey Harper, D.C., and send to 1742 FM 2673 Canyon Lake, TX 78133.

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 Hill Country Family Chiropractic, and to send any and all checks to 1742 FM 2673 Canyon Lake, TX 78133.

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 any 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 following is true and correct. [CPRC: Sec. 132.001(a)]

Signature:
____Date:___________________________

Printed Name: ____