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 herby 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: _____