



13708 MADISON AVENUE • LAKEWOOD, OHIO 44107 • 216.221.2008 • FAX 216.221.6446 • www.gentnerchiro.com

Accident Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help up determine if Chiropractic Care can help you. In order to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Soc. Sec # \_\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_
Home # (\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_ (office use only)
Work # (\_\_\_\_) \_\_\_\_\_ Employer \_\_\_\_\_
Employer Address \_\_\_\_\_

Emergency Contact

Spouse's Name \_\_\_\_\_ Contact # (\_\_\_\_) \_\_\_\_\_ or (\_\_\_\_) \_\_\_\_\_
Other contact if (not married)
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Contact # (\_\_\_\_) \_\_\_\_\_

Please explain in detail how your accident happened. \_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

What were the time & date present accident. \_\_\_\_\_ @ \_\_\_\_\_ a.m. / p.m.
Where did you feel pain immediately after the accident? \_\_\_\_\_
List the extent of injuries as you know them: \_\_\_\_\_
\_\_\_\_\_

Check symptoms you have noticed since the accident:

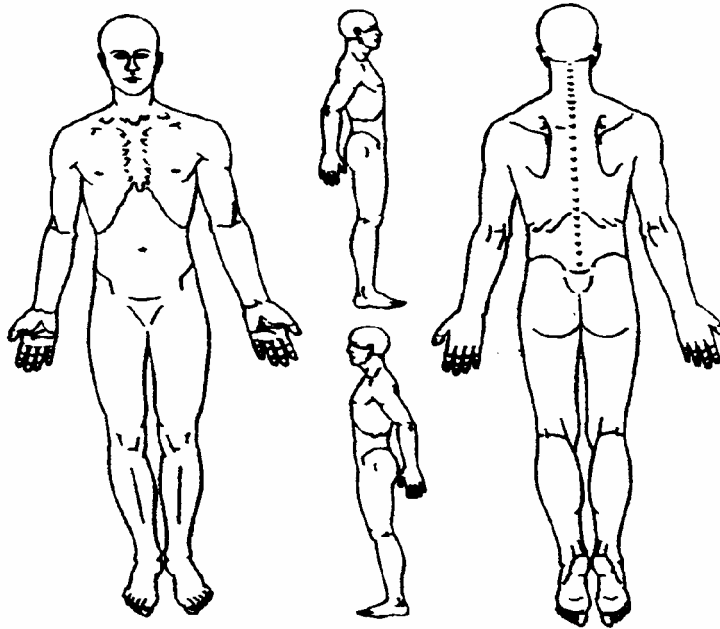
- O Headache O Dizziness O Depression O Fatigue O Stomach Upset
O Light Bothers Eyes O Buzzing in Ears O Diarrhea O Neck Pain O Head Seems too Heavy
O Loss of Memory O Feet are Cold O Stiff Neck O Pins & Needles in Arms O Ear/s are Ringing
O Hands are Cold O Fainting O Problems Sleeping O Loss of Balance O Back Pain
O Face Flushed O Pins & Needles in Legs O Constipation O Tension O Nervousness
O Numbness in Fingers O Loss of Smell O Fever O Irritability O Numbness in Toes
O Loss of Taste O Chest Pain O Cold Sweats O Shortness of Breath O Numbness in leg/s
O Numbness in arm/s O Other \_\_\_\_\_

Where did you go after the accident? \_\_\_\_\_ Did you go to the Hospital? O Yes O No
If yes, admitted? O Yes O No. How long? \_\_\_\_\_ Name of Hospital \_\_\_\_\_
Treatment that was given? \_\_\_\_\_
Was there any other doctor consult after your accident? O Yes O No If so, what was the diagnosis and treatment given? \_\_\_\_\_

Have you ever had any complaints in the involved area before? O Yes O No
If so, what were the complaints? \_\_\_\_\_
Before the accident were you capable of working on an equal basis with others your age? O Yes O No
Are your work activities restricted as a result of this accident? O Yes O No
Since this injury are your symptoms: O Improving O Getting worse O Same
Is there anything that makes your symptoms worse? \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_

Use letters below to indicate type symptoms and location		
A = Ache	B = Burning	C = Stabbing
N = Numbing	P = Pins and Needles	O = Other



**Have you suffered from:** (please check box to indicate yes)

- Dizziness  Backaches  Heart Trouble  Diabetes  Arthritis   
Headaches  Nervousness  Neck Pain  Digestive Disorder  Sinus Trouble

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**Insurance Information**

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness Signature \_\_\_\_\_

Date \_\_\_\_\_



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In consideration of your undertaking my care, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to my insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred. **The Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that we inform you of your privacy rights. A copy of Notice of Privacy Practices is available to you upon request, containing a more complete description of the uses and disclosures of your health information.**
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney, out of the proceeds of any settlement case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. I have read and understand the **GENTNER CHIROPRACTIC FINANCIAL POLICY**. I understand that I am ultimately responsible for full payment of any and all services rendered.
4. I understand that if my insurance carrier has not paid a claim within 60 days of submission, I am responsible for taking an active part in the recovery of the claim. It is understood that a reasonable effort will be made by Gentner Chiropractic to collect the sums due from the insurance company or companies contractually obligated. However, if after 90 days the claim remains unpaid, I agree that I am responsible for payment in full of any outstanding balance. In addition, in the event that Gentner Chiropractic Center must pursue legal action against me to recover any unpaid balance, I acknowledge and agree that I will be responsible for reimbursement of reasonable attorney's fees, all costs of collection and suit, and pre- and post-judgment interest at the maximum amount provided for by law.
5. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Ohio.
6. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
7. This Authorization and Assignment will be in continual effect until revoked by both parties.

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Patient/Insured Signature

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Date

**GENTNER CHIROPRACTIC CENTER  
OFFICE FINANCIAL POLICY**

**GROUP HEALTH:** Most insurance policies cover chiropractic services, but the amount they pay varies per policy. As a courtesy we will verify your insurance for you on your first visit and go over it with you on your second visit. **THIS DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO GROUP BENEFIT LIMITS AND MEMBER ELIGIBILITY AT THE TIME THE CLAIM IS PROCESSED.** It must be fully understood that the policy is between you and your insurance company and you are fully responsible for any amount not paid by your insurance. As a courtesy we will submit your insurance claim for you. We will not, though, enter into dispute between you and your insurance company over a claim. You will receive a monthly statement and you are ultimately responsible for any balance not covered by your insurance. If your insurance policy places a limit on the number of visits they will cover, you will be considered a cash patient once your limit is reached. Please read the "CASH" area below. Please note that it is your responsibility to track your visits. If you have a **COPAY**, you are bound under the terms of the contract with your insurance company to make that payment at the time of your visit, and we are obligated to collect it from you. Please do not ask us to "bill" you for your copay.

**CASH:** We request that 100% of your first visit be paid at the time of service. This includes exam and x-ray fees. For subsequent visits, you are eligible to receive a time of service discount of \$50/visit. This fee must be paid the day of your service. Otherwise, you will be billed for the full amount of all services performed.

**WORKER'S COMPENSATION:** If you are injured on the job, your employer's worker's compensation insurance will pay for care that is **APPROVED** by the BWC. If your claim or treatment is denied, you are responsible for payment either through your personal insurance or personally.

**IMPORTANT:** You must report your injury to your employer before your first visit.

**PERSONAL INJURY/AUTO ACCIDENT:** If you have medical coverage (med-pay) on your auto insurance policy, we will bill them for prompt and direct payment of your care. If you do not have med-pay or are waiting for a settlement with another party, you will be expected to sign a lien which covers the doctor's services through your settlement with the insurance company directly or through an attorney.

**REGARDLESS OF ANY SETTLEMENT, YOU AS THE PATIENT, ARE RESPONSIBLE FOR ALL MEDICAL BILLS. PAYMENT IS NOT CONTINGENT ON ANY SETTLEMENT.**

***ALL PATIENTS PLEASE READ:***

As stated above, insurance co-pays and cash patient payments are expected the day of service. To help accommodate you, we have a credit card authorization form available for you to put your credit card and signature on file. We will be happy to process your payments with this on file. Our office policy is to not allow any patient balances over \$150.00. This encompasses balances of deductibles, copays, co-insurance, and cash visits. Care will be suspended until a patient's balance is brought below the allowed amount. You will be expected to remit payment in full after receiving our statement or contact our billing dept. to establish an agreed upon monthly payment plan. If your balance continues past 90 days without a payment agreement, your account will be referred to an outside collections resource for non-payment of services rendered. Once sent to collections, there will be a 1.5% interest charge added every month that the balance is not paid. For your convenience, we accept cash, personal check, money order, VISA, and MASTERCARD as payment. There will be a \$25.00 fee added to your balance for any returned checks.

If you have any questions, please do not hesitate to ask our receptionist or billing/insurance manager.

***I have read and understand the office financial policy. This is an agreement made between the doctor's office and myself. I understand that failure to abide by this agreement could result in termination of care and further collections activity.***

\_\_\_\_\_  
PATIENT or PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS / DATE