Auto Accident Intake Form

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
c Female c Male

Marital Status:
c Single c Married c Domestic Partner c Separated c Divorced c Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
c Mobile Phone c Home Phone c Work Phone c Email

2. Automobile Insurance Information

Driver of automobile you were in: _____ Name of your/their Auto Insurance Company: _____

Policy #: _____ Claim #: _____

Auto Insurer Phone: _____ Name of Insurance Adjuster: _____

3. Date, Time, and Location of Accident?

_____

4. Did the accident occur while working?

c Yes

c No

If yes, were you in a company vehicle?

_____

5. Light/Dark Outside?

c Daylight c Dawn c Dusk c Dark

Road/Weather Conditions at time of Accident?
○ Clear ○ Dark ○ Dry ○ Wet ○ Foggy ○ Icy ○ Snow Covered

Road Type:
○ Asphalt ○ Concrete ○ Dirt ○ Gravel ○ Other

Were you aware the accident was going to occur prior to impact?
○ Yes, I was aware of the approaching collision prior to impact ○ No, it caught me by surprise

6. Did you lose consciousness upon impact?

○ Yes
○ No

If yes, for how long?

_____

7. Did you experience flashes of light or explosion in your head?

○ Yes
○ No

If yes, for how long?

_____

8. After the time of the accident, did you become or experience any of the following? Check all that apply.

☐ Confused	☐ Disoriented	☐ Light headed
☐ Dizzy	☐ Nauseated	☐ Blurred vision
☐ Ringing/buzzing in ears	☐ Loss of balance	☐ Other

If other, specify:

_____

9. Did the police come to the accident scene?

○ Yes
○ No

10. Is there a Police report?

○ Yes
○ No

Post -MVA Care

11. Were you hospitalized/taken to the ER?

- ○ Yes, immediately
- ○ Yes, next day
- ○ No
- ○ Yes, later that day
- ○ Yes, other

If yes, other please give details:

_____

12. How were you transported to the hospital?

- ○ Ambulance
- ○ Private transportation
- ○ Air lifted
- ○ Drove myself

13. Name of Hospital: _____

How long were you in the hospital? _____

14. What did the hospital do for your injuries?

- ☐ Prescription medication
- ☐ MRI
- ☐ Splints
- ☐ X-rays
- ☐ Surgery
- ☐ Back Brace
- ☐ CT Scan
- ☐ Cervical/Neck Collar
- ☐ Other

If other, please explain:

_____

15. What was their diagnosis? Also, please list any additional relevant details on what hospital did for your injuries.

_____

_____

_____

_____

16. What did they recommend for follow-up care?

_____

_____

_____

_____

17. Did they refer you to another physician? Ex...your primary, orthopedist, neurologist, this office, etc...

_____

_____

_____

_____

18. **Were any other doctors consulted after your accident? If yes, give details below. (Dr. Name(s), Specialty, date first seen, treatment type, frequency and length of care)**

Accident Details

19. **Were you restrained/wearing a seatbelt?**

- ○ Yes - seatbelt
- ○ Yes - carseat
- ○ No

If yes, did you receive any injury or bruise from the seatbelt? Please explain.

20. **Did your airbag deploy?**

- ○ Yes - front only
- ○ Yes - left side only
- ○ Yes - right only
- ○ Yes - front & side
- ○ No

If yes, did you receive any bruises/burns from the airbag? Please explain.

21. **Did your head hit the head rest during the accident?**

- ○ Yes
- ○ No

22. **Was the position of your headrest altered from the accident?**

- ○ Yes
- ○ No

23. **Was the seat adjustment altered or was the seat broken as a result of the accident?**

- ○ Yes
- ○ No

If yes, please explain:

24. Your head position at the time of impact:

- ○ Looking straight ahead
- ○ Right level
- ○ Right down
- ○ Right up
- ○ Looking down
- ○ Left level
- ○ Left down
- ○ Left up
- ○ Looking up

25. Head made impact with:

- ☐ Airbag
- ☐ Steering wheel
- ☐ Side window/door
- ☐ Nothing
- ☐ Front windshield
- ☐ Dashboard
- ☐ Another person's body
- ☐ Rearview mirror
- ☐ Back of front seat
- ☐ Headrest

26. Were you wearing glasses or a hat at the time of impact?

- ○ Yes
- ○ No

If yes, were they still on after the accident?

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27. Where were your hands?

- ○ One at the wheel
- ○ Not applicable
- ○ Both hands on the wheel

28. Your body position at the time of impact:

- ○ Straight ahead
- ○ To the left
- ○ To the right

29. Body was thrown:

○ Forward ○ Backward ○ Left ○ Right ○ Unknown

Chest made impact with:

○ Airbag ○ Steering wheel ○ Dashboard ○ Back of front seat ○ Side window/door
○ Another person's body ○ Nothing

Shoulder(s) made impact with:

○ Steering wheel ○ Dashboard ○ Back of front seat ○ Door panel ○ Center console
○ Another person's body ○ Nothing

Hip(s) made impact with:

○ Steering wheel ○ Dashboard ○ Back of front seat ○ Door panel ○ Center console
○ Another person's body ○ Nothing

Collision Details

30. Please list the year, make, and model of your vehicle:

_____

31. Please list the year, make, and model of the other vehicle(s) involved in the accident:

_____

32. Was your car moving?

ⓒ Yes ⓒ Yes, but braking ⓒ No ⓒ Unknown

If so, speed at impact? (mph)

ⓒ <5 ⓒ 6-10 ⓒ 11-15 ⓒ 16-20 ⓒ 21-30 ⓒ 31-40 ⓒ 41-50 ⓒ 51-60 ⓒ 61-70 ⓒ >70 ⓒ Unknown

33. Was the second vehicle moving?

ⓒ Yes ⓒ Yes, but braking ⓒ No ⓒ Unknown

If so, speed at impact? (mph)

ⓒ <5 ⓒ 6-10 ⓒ 11-15 ⓒ 16-20 ⓒ 21-30 ⓒ 31-40 ⓒ 41-50 ⓒ 51-60 ⓒ 61-70 ⓒ >70 ⓒ Unknown

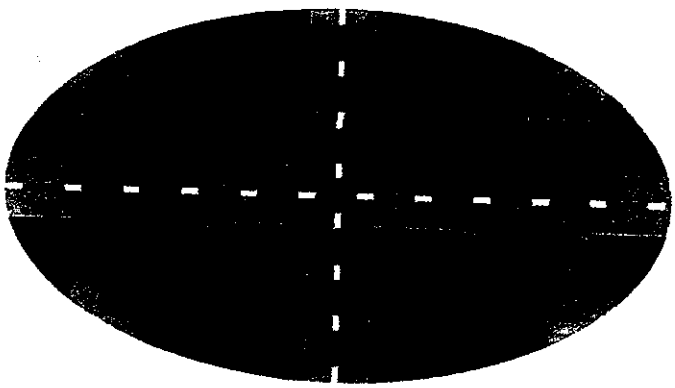
34. Was the third vehicle moving?(If applicable)

ⓒ Yes ⓒ Yes, but braking ⓒ No ⓒ Unknown

If so, speed at impact? (mph)

ⓒ <5 ⓒ 6-10 ⓒ 11-15 ⓒ 16-20 ⓒ 21-30 ⓒ 31-40 ⓒ 41-50 ⓒ 51-60 ⓒ 61-70 ⓒ >70 ⓒ Unknown

35. Please illustrate the accident with all involved vehicles (if applicable) below.



I was ○ driving ○ a passenger in a _____ on a _____.
(type of vehicle) (i.e., street or highway)

The other vehicle was a _____.
(type of vehicle)

I was ○ in front, left ○ in front, right ○ in back, left ○ in back, right
○ wearing seat belt ○ air bag deployed ○ struck headrest
○ facing front ○ turned

Were other people in the car? ○ no ○ yes

If yes, were they hurt? ○ no ○ yes

36. Check all symptoms you have noticed SINCE the accident?

☐ Headaches/Migraines	☐ Neck pain	☐ Upper back pain
☐ Shoulder pain	☐ Mid-back pain	☐ Low back pain
☐ Depression	☐ Buzzing in ears	☐ Arm pain
☐ Leg pain	☐ Jaw pain/Clicking	☐ Dizziness
☐ Fatigue	☐ Loss of memory	☐ Cold hands/feet
☐ Numbness/tingling	☐ Loss of smell	☐ Irritability
☐ Digestive problems	☐ Joint pain/stiffness	☐ Menstrual problems
☐ Pinched nerve	☐ Loss of sleep	☐ Loss of balance
☐ Chest pain	☐ Sensitivity to light	☐ Fever
☐ Nervousness	☐ Vision problems	☐ Urinary problems
☐ Sleeping problems	☐ Paralysis	☐ Tension
☐ Fainting	☐ Pins/needles sensation	☐ Stomach upset
☐ Difficulty swallowing	☐ Sciatica	☐ Sinus pain
☐ Sore muscles	☐ Head feels heavy	☐ Other

If other, please list:

Chief Complaint(s)

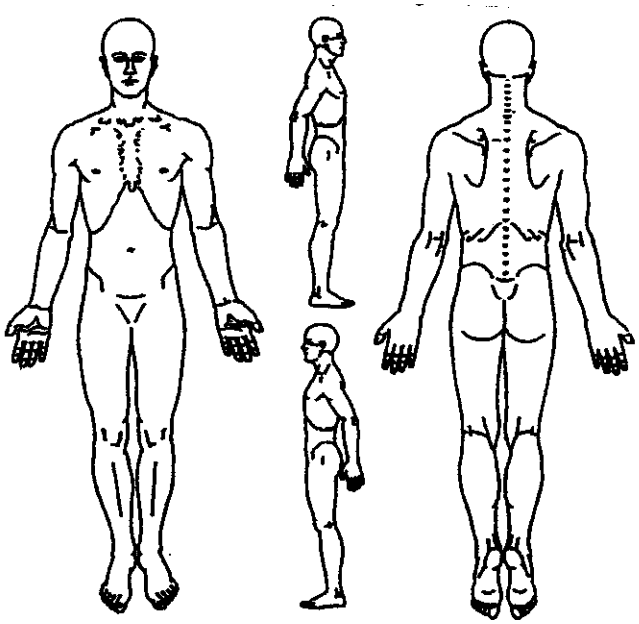
Complaints Listed Individually

37. Mark all the areas of the body where you feel the described sensations. Use the appropriate symbol. Include ALL AFFECTED AREAS.

A = ACHE
P = PINS & NEEDLES

B = BURNING
S = STABBING

N = NUMBNESS
O = OTHER



Auto Insurance Information

Patient Auto Insurance Details

Patient Name: _____ Date of Birth: _____

Patient's Auto Insurance Company _____ Insurance ID: _____

Accident Claim #_____

Auto Policy is under what name: _____Relationship to Patient: _____

Agent Name: _____Agent Phone: _____

Agent Email: _____Agent Fax: _____

Is there Medical Pay? Y / N Amount Utilized _____ **Amount Remaining** _____

Is acupuncture covered (for example, codes 97810 or 97811)? Y / N

For physical therapy, is pre-authorization required? Y / N **Is referral from PCP required?** Y / N

Is patient's policy the at-fault policy? Y / N

At-Fault Party or Other Party Auto Insurance Details

At-Fault/Other Party Auto Insurance Company _____ Insurance ID: _____

Accident Claim #_____

Auto Policy is under what name: _____ Relationship to Patient: _____

Agent Name: _____Agent Phone: _____

Agent Email: _____Agent Fax: _____

*Our office may attempt to confirm your benefits, but as the customer of your insurance company, you will be able to gain access to the details above faster (and more completely) than anyone.

ASSIGNMENT AND CONVEYANCE OF LIEN INTEREST - Personal Injury, Auto Accident or Worker's Compensation only

I hereby execute and provide **Irrevocable Lien Interest and Assignment of Proceeds** to apply to all monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/medical payment insurance policy to which I am entitled, and from which I am to pay in the form of an insurance settlement(s), claim(s), judgment(s), or verdict(s) resulting from any identified accident. The insurance carrier is instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds to bills submitted by the doctor and/or treating facility, shall be paid directly to the above named doctor and/or treating facility. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable to my account to such named doctor and treating facility and remit payment of all such sums directly to such named doctor and/or treating facility upon receipt of my settlement award(s).

_____ _____

Patient (or Guardian) Signature Date

FINANCIAL RESPONSIBILITY AGREEMENT

- I understand that as a patient of Dr. Jasmine Kim, it is my responsibility to know my insurance plan and what benefits are covered, to know if and when a referral is necessary and to have verified that the providerI am seeking care from is in network with my benefits. Any balance remaining after insurance has paid is my responsibility in full.
- I also understand and accept that I will be responsible for charges in the following situations in accordance with state provider billing guidelines.

1. All payments are due at the time of service, including copays, co-insurance, deductibles, and non-covered services.
2. Any covered and non-covered services are the responsibility of the patient at the rate determined by the insurance company's explanation of benefits. Final approval of coverage is based on the explanation of benefits after the claim has been filed.
3. If unable to make your appointment, please notify our office at least 24 hours' notice out of respect and courtesy to other patients. After two missed/cancelled visits without 24-hour notice, you will be charged $50.00 for each visit that is missed.
4. It is our policy to collect $25 for returned checks to cover any fees that apply from the transaction.
5. If full payment is not received, the card on file will automatically be charged for the remaining balance that the end of each business day unless other arrangement are made in advance. If you are unable to pay in full, please ask about payment plan options.
6.

Designation of Authorized Representative

- I do hereby designate Dr. Jasmine Kim Inc to the full extent permissible under the Employee Retirement income Security Act of 1974("ERISA") and as provided in 29CR 2560-503-1(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or their health care expenses incurred as a result of the service I receive from Dr. Kim. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, health care benefit plan reimbursement and to pursue any or the applicable remedies.
- I do hereby authorize Dr. Jasmine Kim to act on my behalf to pursue claims and exercise all rights in order to collect payments with respect to any medical or other health care expenses incurred as a result of the service I receive from Dr. Jasmine Kim.

Payment method. Self-Pay. Health Insurance. Auto insurance. Worker's Compensation. Other

If you are here for treatment due to an Auto injury or WC injury, please ask front desk for additional paperwork.

Insurance Carrier_____ Policy number_____ Group number_____

Insured's Name_____ Insured's date of birth_____ relationship to insured_____

Billing address, if different from patient.

Name_____ Address_____

City_____ State_____ Zip code_____-

By signing this form, I agree to this financial agreement and acknowledge that I have read and understand that I will assume full responsibility for the total billed charges related to any and all non- covered services.

Signature of patient_____ date_____

INFORMED CONSENT

Medical doctors, Chiropractic doctors, Osteopathic doctors, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I do hereby give my consent to the treatment that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, physical therapy, diagnostic x-rays, acupuncture.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and /or other licensed doctors of chiropractic who now or in the future treat me while employed by, working, or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment. I do not expect the doctor to be able to anticipate all risks and complication, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time b based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses that are preexisting given by anther heath care practitioner or are not related to the spinal structural conditions treated at this clinic. Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

I ,_____ have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below, I agree to the care, I intend this consent form to cover the entire course for treatment for my present condition and for any future condition for which I seek treatment.

Signature_____ date_____

CONSENT TO TREATMENT OF A MINOR

As of this date, I have the egal right to select and authorize health care services for the minor child named below. If applicable, under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse, or their parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

I authorize this minor child, _____ to receive treatment at this office when I am not present. Yes. No

Relationship to child _____

Parent or Guardian signature_____ date_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Health and Portability and aAcountability Act of 1996("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential.

In the course of your care a s a patient of at the office of Dr. Jasmine Kim, we may need to use or disclose personal and health related information about you in the following ways:

- Your personal health information including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer if they are responsible for payment of your services.
- Your name, address, email, phone number, and your health care records may be used to contact you regarding appointment reminders or other appointment related issues, to provide information about alternatives to your present care or other health related information that may be of interest to you. Periodically, thank you letters, referral cards, newsletters, birthday cards, postcards, paper clippings or email messages may be sent.

If you are not at home to receive an appointment reminder, a message me be left on your answering machine or with another member of your family of the household. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.

- Under federal law, we are also permitted or required to use or disclose your health insurance without your consent or authorization in the following circumstances.
- We are providing health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you but in our professional judgement, we believe that you intend for us to provide care.
- If we are order by the courts or another appropriate agency

Any use of disclosure of your protected health information other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive care from us. We may also mail information to you regarding your care, insurance forms, or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like information in a different form, please advise us in writing as to your preferences.

We are required by state and federal law to maintain the privacy of your patient file and to protect the health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to your privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your information in our files.

In addition, we may disclose your Personal Health Information to a family or close friend they accompany you while receiving health care services or if we determine that it is in your best interest so we can provide you with the best health care possible. We may also disclose your PHI to a family member or someone else who helps pay for your health care treatment.

- You have the right to inspect and copy PHI that me be used to make decisions about your care, including medical and billing records. You must submit your request in writing. We will respond within 30 days.
- Email risk and responsibility. As the internet is not secure or private, unauthorized people may be able to intercept, read and possibly modify email you send to or receive from us.it is solely your responsibility to protect your own email account, password and computer against access by unauthorized people. Since emails can easily be copied, printed, and forwarded, you should be careful regarding to whom you send information. We reserve the right to save your email and include your email for information contained in your medical record. You should immediately inform us of a change in your email address. If you wish to withdraw the consent to communicate by email, you must send it in writing stating such.
- You understand that if you opt for appointment reminders via text that you will receive text reminders. You also understand that if you respond to this to change/reschedule/confirm via text, it utilized email to relay communication.
- You understand that it is your choice to communicate via social media platforms and that if you choose to communicate via social media, you have consented to utilizing this platform for future communication.

If you have a complaint regarding our privacy notice and /or privacy practices or would like further information about our privacy policies and practices, please contact Dr. Jasmine Kim.

Dr. jasmine Kim Inc will use reasonable means to protect the privacy of the patient's health information. However, because of the risks outlined above, we cannot guarantee that email will be confidential. Additionally, Dr. jasmine Kim Inc will not be liable in the event that you or anyone else inappropriately uses or accesses you email. We sill not be liable for improper disclosure of your health information that is not caused my intentional misconduct by agents of Dr. Jasmine Kim, Inc.

By signing below, I acknowledge that I have read and fully understand this consent form. I understand that this consent is valid until such time as I revoke the consent as outline above, except to the extent that a person who is to make communication has already acted in reliance upon this authorization.

_____. _____. _____

Name please print(minors name) signature Date