Auto Accident Intake Form

Today's Date________________________________

Name:___________________________________

Address: _________________________________

____

Sex MALE FEMALE

Occupation:______________________________

Employer:________________________________

Employer Phone #: _________________________

Primary Phone:___________________________

Secondary Phone:_________________________

Social Security #:_________________________

Date of Birth:____________________________

Marital Status:___________________________

Have you ever been to a chiropractor before?

YES NO

Accident Information

Date of accident:___________________ Time of accident:__________________

Were the police notified? YES NO

Were you wearing a seatbelt? YES NO

Were you the ___driver ___passenger ___pedestrian

If passenger, were you sitting in ___front ___right backset ___left backseat

Did **your** vehicle strike the other? YES NO

Did the **other** vehicle strike yours? YES NO

Please describe in detail how the accident happened?____

____

____

____

Auto Accident Insurance Information

Your Insurance Company:__________________________________ Phone #______________________

Address:____City/State/Zip______________________

Claim #:_______________________________________ Do you have an attorney? YES NO

Name of other vehicles driver:____

Other vehicles insurance company:____

Other vehicle insurance company phone #:_________________________ claim #:__________________

Post-Accident Information

Where did you feel pain **immediately** after the accident?____

Rate your pain **today** on a scale of 1-10 (1 being no pain and 10 being unbearable)__________________

Please describe your **pain(s)**(burning, sharp, tight etc) and **location(s)** :____________________________

____

____

Have you experienced pain in this location(s) before? **NO** **YES** (when)______________________

When did these symptoms begin? **IMMEDIATLEY** **LATER, SAME DAY** **DIFFERENT DAY**

Since the accident has your condition: **IMPROVED** **WORSENED** **STAYED SAME**

Does anything make your condition improve? **NO** **YES** ___________________________________

Does anything make your condition worse? **NO** **YES**____________________________________

Have you seen any other doctor(s) since the accident: **NO** **YES** (name)_____________________

Did you require hospitalization: **NO** **YES** (name)_______________________________________

Did you have an X-ray, MRI or any other tests for this condition? **NO** **YES** (describe)______________

Check off current symptoms: ___headaches ___neck pain/stiffness __mid back pain ___low back pain ___nausea ___cold hands/feet ___leg pain ___pain behind eyes ___loss of smell ___loss of taste ___chest pain ___dizziness ___shortness of breath ___ringing in ears ___fatigue ___anxiety ___sleeping problems ___tension ___tension ___fainting ___irritability ___depression ___confusion ___constipation ___nervousness ___other:_________________

Health History:

Please list all medications you are currently taking for this or any health condition (including vitamins):

____

____

Please list any allergies (including medications, environmental, food): ______________________________

____

Please list **any** medical conditions that you **currently have or have had** (cancer, diabetes, high blood pressure, dizziness etc):____

____

____

Please list **any** surgeries you have had from **birth-present**:____

____

____

Do you smoke? **NO** **YES** (how much)______________ (for how long)__________________________

Former Smoker, but quit Years since last smoked__________________________

For Women: Are you currently taking birth control? **NO** **YES** (name)_____________________

Are you pregnant? **NO** **YES** due date_____/______/______

Patient Signature:____ Date:_________________

INFORMED PATIENT CONSENT

Patient Name: **Account #:**

- My signature below indicates that I understand that if I am accepted as a patient of STEELE CHIROPRACTIC, I am authorizing them to proceed with any further treatment that may be necessary. I understand that there are risks that can be associated with care including stroke, increased nerve sensitivity/numbness, and increased muscle and joint pain. I also understand that any risks involving chiropractic treatment will be explained to me in depth upon request.
  ______ staff initials

____

Patient Signature **OR** Parent/Guardian/Personal Representative Signature Date

____

Printed Name and Relationship to Patient

- My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices for Steele Chiropractic and have read and understood its content.

____

Patient Signature **OR** Parent/Guardian/Personal Representative Signature Date

____

Printed Name and Relationship to Patient

BUSINESS/FINANCIAL BILLING ARRANGEMENTS

_____ **NO INSURANCE/PRIVATE PAY:** Payment in full is expected at the time of service.

_____ **COMMERCIAL INSURANCE:** As a service to our patients, Steele Chiropractic accepts assignment of insurance benefits and bills the insurance company for services provided at our office. Insurance is a contract between you and your insurance company. You will be responsible for any deductible, coinsurance and copays. Copays are expected to be paid at the time of service. Failure to present the correct insurance information at the time of your appointment may result in the entire balance becoming your responsibility. This also includes returning requests of information to your insurance company in a timely manner. While we do our best to estimate your insurance benefits, the insurance company makes the final determination on your benefits and coverage. If we are out of network with your insurance company, you are responsible for any portion of the charges not covered by them.

_____**MEDICARE:** We are a participating provider with Medicare and therefore agree to bill and accept assignment from Medicare. Chiropractic manipulations to the spine to improve an injury or health condition are considered medically necessary and are the only service that is covered by Medicare. Medicare does not cover maintenance manipulations, manipulations to an extremity, exams, therapies or supplements and supplies at this office. I understand that if I do not have a supplemental insurance, I will be responsible for all deductible, coinsurance, and non-covered services at this office. If you do have a Medicare supplemental policy, most will cover the Medicare coinsurance. If you have chosen additional Riders on your policy, it may cover deductible services as well. Any supplemental plans written in the state of Wisconsin also follow the Wisconsin State Mandate, meaning many of them will cover maintenance manipulations, manipulations to an extremity, exams, and therapies.

_____**MEDICARE ADVANTAGE PLAN:** We are a participating provider with many Medicare advantage plans, and we accept assignment of benefits for services provided at our office. Most of these plans follow Medicare guidelines, and therefore only cover chiropractic manipulations to the spine to improve an injury or health condition. They normally do not cover maintenance manipulations to the spine, manipulations to an extremity, exams, or therapies. I understand that I will be responsible for all deductible, coinsurance, copays, and non-covered services at this office.

_____**STATE MEDICAL ASSISTANCE/FORWARDHEALTH:** We are a participating provider with Wisconsin State Medical Assistance and agree to bill and accept assignment of benefits for the services provided at our office. Chiropractic manipulations to the spine and exams are the only services covered by Medicaid, and they are limited to 20 visits per condition. Medicaid does not cover maintenance manipulations to the spine, manipulations to an extremity, therapies, or supplements and supplies at this office. I understand that I am responsible for all copays and non-covered services at this office.

_____**WORKERS COMPENSATION/AUTO ACCIDENT:** We agree to bill and accept assignment of benefits from your workers compensation or auto carrier. I understand that opening a claim does not guarantee acceptance of fault nor

does it guarantee payment. It can also take a long time for settlement to be reached in these cases, and some companies will not pay until settlement has been reached. In these circumstances, I understand I may be asked to begin making payments on my account. I also understand that I am responsible for all charges that are denied or non-covered by my insurance carrier.

- PAYMENT is expected at the time of service, unless other arrangements have been made.
- INSURANCE is a contract between the patient and the insurance company and therefore, it is the responsibility of the patient to make sure the account remains current. This includes presenting correct insurance information at the time of service and returning any and all information necessary to the insurance company to get their claims processed. While we will do everything, we can to assist in getting your claims paid and processed, you are ultimately responsible for the services received at this office.
- Patients involved in LITIGATION, WORKERS COMPENSATION, OR AUTO ACCIDENT cases are ultimately responsible for the services received at this office.
- When asking us to bill any insurance, you are acknowledging that the insurance company will pay this office directly for any covered services provided by this office.
- If there is a patient balance, we will send you a monthly statement. Patients are responsible for all charges for services rendered and supplies provided by this office. Payment in full is due within 30 days of receipt of this statement, unless other financial arrangements have been made.

By signing this agreement, I acknowledge that I understand and agree to the policies and terms contained herein.

____

Patient Signature OR Parent/Guardian/Personal Representative Signature Date

____

Printed Name/Relationship to Patient

____

Printed Patient Name and Chart #

Patient Consent for Electronic Reminders

Patients at Steele Chiropractic may be contacted via text messaging to be reminded of an appointment. If at any time I provide a phone number at which I may be contacted, I consent to receive appointment reminders via text from Steele Chiropractic.

______ (Patient initials) I consent to receive text messages from Steele Chiropractic on my cell phone. I understand that this request to receive text messages will apply to all future appointment reminders unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders is_______________________________.

Steele Chiropractic does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Patient Printed Name and Chart #: ____

Parent/Representative Signature: ___________________________Date____________________________

Patient Signature ____ Date ___________________________

Revocation:

__I hereby revoke my request to receive any future appointment reminders via text messages.

NOTE: This revocation only applies to communications from this Practice.