Bel-Ray Wellness Center

NOTE:
This questionnaire will allow you to describe your automobile accident in detail. Please complete it carefully as the information will assist us in evaluating and documenting your condition.

CONFIDENTIAL

AUTOMOBILE ACCIDENT QUESTIONNAIRE

PATIENT'S FULL NAME_____

A. VEHICLE YOU WERE IN

1. **Date of Accident**: _____
2. **What was YOUR location in the vehicle?**
   Driver Front Passenger Rear Left Passenger Rear Middle Passenger Rear Right Passenger
3. **Were you wearing a restraint belt?**
   Shoulder-Lap Belt Shoulder Belt Lap Belt No Restraint
4. **What was the vehicle you were in doing?**
   MARK ONLY **ONE** ANSWER FOR THE ABOVE QUESTION
   A. **Vehicle stopped for…**
      Traffic Light Intersection Stop Sign Traffic Pedestrian Parked Other _____
   B. **Vehicle slowing down for…**
      Traffic Light Intersection Stop Sign Traffic Pedestrian Turning Parking Other
   C. **Vehicle moving…**
      Slowly Moderately Fast ____MPH Accelerating Other_____
   D. **Vehicle doing other…**
      Explain:_____
5. **Did the vehicle airbags deploy?**
   Yes No The vehicle did not have airbags
6. **Where was the impact on your vehicle?**
   Left Right Front Rear Side Unknown Head-on
7. **What damage did the vehicle you were in sustain?**
   Minimal Moderate Extensive Totaled Unsure Other _____
8. **Was your vehicle towed from the scene?** Yes No
9. **Who has been assigned "at fault" for this accident?**
   Self Other Driver Undecided

B. AT THE MOMENT OF IMPACT

1. **Were you prepared for the accident?**
   Accident a complete surprise Aware of impending collision Braced for impact
2. **Where were you looking at the time of accident?**
   Straight Ahead Left Right Over Left Shoulder Over Right Shoulder Down Unknown
3. **What part of your body , if any, struck the interior of the vehicle?**
   Head Chest Knee Leg Arm Shoulder Foot Other_____
4. **Did you lose consciousness?** Yes No

C. IF OTHER VEHICLES INVOLVED IN ACCIDENT

1. **What was the other vehicle doing?**
   MARK ONLY **ONE** ANSWER FOR THE ABOVE QUESTION
   A. **Vehicle stopped for…**
      Traffic Light Intersection Stop Sign Traffic Pedestrian Parked Other _____
   B. **Vehicle slowing down for…**
      Traffic Light Intersection Stop Sign Traffic Pedestrian Turning Parking Other
   C. **Vehicle moving…**
      Slowly Moderately Fast ____MPH Accelerating Other_____
   D. **Vehicle doing other…**
      Explain:_____
2. **What damage did the other vehicle sustain?**
   Minimal Moderate Extensive Totaled Unsure Other _____
3. **Where was the impact on the other vehicle?**
   Left Right Front Rear Side Unknown Head-on
4. **Was there a third vehicle involved?** Yes No

Patient or Guardian Signature: _____ **Date:** _____

Bel-Ray Wellness Center

PATIENT'S FULL NAME_____

D. POST ACCIDENT

1. **Initial Reaction**
   Shaken Upset Nervous Confused Frightened Dazed Distressed Dizzy Lightheaded Weak Other_____

2. **Did the Police arrive at the accident site?** Yes No **Was a Police report filed?** Yes No

3. **Were the EMS at the scene?** Yes No **Did you go to the hospital?** Yes No
   If yes, how were you transported? Ambulance Driven by _____
   If no, where did you go after the accident? Continued with activities Drove home Arranged a ride Other_____

4. **Where, if any, was your pain at the time of the accident?** Neck Mid-Back Low-Back Hips Arms
   Legs Other_____ Other_____ **How would you describe the pain?**_____
   _____

5. **Have you receive any treatment since the accident?** Yes No **If yes, what treatment?**_____
   _____

Prior to the accident:
Pain Scale Severity

Neck	0	1	2	3	4	5	6	7	8	9	10
Mid-Back	0	1	2	3	4	5	6	7	8	9	10
Low-Back	0	1	2	3	4	5	6	7	8	9	10
Hips	0	1	2	3	4	5	6	7	8	9	10
Arms	0	1	2	3	4	5	6	7	8	9	10
Legs	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

At the time of the accident:
Pain Scale Severity

Neck	0	1	2	3	4	5	6	7	8	9	10
Mid-Back	0	1	2	3	4	5	6	7	8	9	10
Low-Back	0	1	2	3	4	5	6	7	8	9	10
Hips	0	1	2	3	4	5	6	7	8	9	10
Arms	0	1	2	3	4	5	6	7	8	9	10
Legs	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

E. AUTO INSURANCE (provide the information specific to who is responsible for bill)

1. **Name of Insurance Co. -** _____
2. **Claim # -** _____
3. **Name of contact from Ins. Co. -** _____
4. **Phone and fax of contact -** _____
5. **Signed Authorization release from Ins Co. (If pt. does not have this, please have them sign medical auth. release from clinic..)**

F. ADDITIONAL INFORMATION

Would you like for your health insurance to be billed in addition to the auto insurance claim? **Yes** **No**

Patient or Guardian Signature: _____ **Date:** _____

Bel-Ray Wellness Center

Office: (816) 322-4774
Fax: (816) 322-6670

BelRayWellness@gmail.com
www.Bel-RayWellnessCenter.com

It is at the insurance company's discretion to approve or deny medical treatment based on the policy holders insurance benefits. The insurance company's rules and regulations vary, so it is up to the patient to be informed as to what additional steps must be taken to assure claim coverage.

It is the patients responsibility to call the insurance company responsible for payment of medical care and open a medical claim prior to treatment.

If the insurance company denies payment for medical coverage the balance due is patient responsibility.

I have read and understand my responsibilities in pursuing personal injury care as a result of the accident.

_____ _____

Printed Name Date

_____ _____

Signature Date

DOCTOR'S LIEN

To: _____
_____
_____

_____
_____
_____

McCandless Chiropractic, LLC
Bel-Ray Wellness Center
Dr. Jonah McCandless and
Dr. Jeffrey Breithaupt
425 W Pine St. Ste. A
Raymore, MO 64083
816-322-4774

Patient Name:_____

RE: Medical Reports and Doctor's Lien

I do hereby authorize the above doctor to furnish you, my attorney/ insurance carrier, with a full report of his case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident in which I was involved.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident, and authorize and direct you, my attorney/ insurance carrier, to pay directly to said such sums as may be due and owing him for services rendered to me, and to withhold such sums from such I do hereby authorize the above doctor to furnish you, my attorney/ insurance carrier, with a full report of his settlement, claim, judgment, or verdict as may be necessary to protect said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for services rendered to me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may recover said fees.

Dated: _____Patient/Guardian Signature: _____

The undersigned does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor above named.

This lien does not constitute a request or agreement between the parties for the attorney or law firm to act as a collection agency for the above named doctor/doctor's office

Dated: _____Authorized Signature: _____

NOTICE: Please date, sign, and copy this form.

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Raymore, MO 64083

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Authorization for the Release of Medical Records

Patient Name: _____ Date of Birth:_____
(also list maiden name/other names used)

I hereby request and authorize:

Bel-Ray Wellness Center
425 W. Pine St, Suite A
Raymore, MO 64083

_____To Disclose information to: _____To Receive Information from:

Provider:_____

Address:_____

City/State/Zip_____

Information to be disclosed include copies of:

_____Entire Record
_____Progress Notes
_____Physical Exam forms
_____Daily chart notes
_____X-ray Reports
_____X-ray Films
_____Other, specify:
_____

Purpose for disclosure:

_____ Treatment, Payment OR _____ Other (Specify)_____

This authorization will be effective for six months after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

_____Date:_____
Signature of Patient

OR

_____Date:_____
Signature of Legal Representative/Relationship