ACCIDENT INFORMAION PACKET

Date: _____

To: _____

_____

Notice of Health Practitioner Lien

(Patient: please fill out all highlighted portions)

Notice is hereby given, **Dr. Amber Bent, D.C. / Dr. Matt Herrin, D.C**. at **1600 Gravois Rd, High Ridge, MO 63049**, rendered chiropractic and other health care treatment and services to:

_____ for personal injuries on or about _____ for which _____ is alleged as liable.

Dr. Amber Bent, D.C. / Dr. Matt Herrin, D.C. hereby claims a lien for services rendered through _____ in the amount of $_____, upon all claims, demands suit, or rights of action by _____ against _____ and which alleged liability is insured by _____.

Patient: _____

SSN#: _____

Address: _____

_____

_____

Authorization to Pay Benefits

I hereby authorize payment directly to the provider of medical benefits what would be due. I hereby authorize my attorney / insurance company, _____ to pay directly to the provider such sums which may be due as a result of this accident and to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protest said doctor or clinic.

Patient Signature: _____ Date: _____

Please fill out The Patient's Information:

Car Insurance Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Adjuster: _____ Phone #: _____

Agent: _____ Phone #: _____

Policy #: _____ Claim #: _____

Driver's License #: _____ State: _____

Lawyer/Law Firm: _____

Phone #: _____ Fax #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Please fill out The Other Party's Information (if available):

Name: _____ Phone #: _____

Car Insurance Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Agent: _____ Phone #: _____

Policy #: _____ Claim #: _____

Driver's License #: _____ State: _____

Describe Your Vehicle

Today's Date:_____

Make: _____ **Model:** _____ **Year:** _____

1. Vehicle Type **Estimated Speed:** _____

□ Sportscar □ Coupe □ Sedan □ SUV/Van □ Station Wagon □ Pick-up Truck

2. Vehicle size

□ Compact □ Mid-sized □ Full-sized

Describe the Accident

3. Date of Accident: ____/____/_____ **Location of accident**:_____

4. Actions of Patient's vehicle:

□ Crossing an intersection □ Stopped at an intersection □ Turning: left / right
□ Stopped for a pedestrian □ Stopped for traffic
□ Traveling at posted speed limit □ Traveling faster than posted speed limit

5. How was the Patient's vehicle hit:

□ Hit head on □ Was rear ended □ Was hit on the left front
□ Was hit on the right front □ Was hit on left rear □ Was hit on right rear

6. Damage to Patient's vehicle

□ Complete □ Extensive □ Minimal □ Moderate

7. Describe the Other vehicle

□ Compact □ Mid-sized □ Full-sized □ Pick-up truck □ Semi-trailer

8. Damage to the Other vehicle

□ Complete □ Extensive □ Minimal □ Moderate

9. Weather conditions

□ Sunny □ Cloudy □ Foggy □ Dark
□ Clear □ Drizzling □ Rainy □ Snowy □ Stormy

10. Road Condition

□ Dry □ Damp □ Wet
□ Snowed over □ Iced over □ Dry with icy patches

Describe the Moment of Impact

11. Body position at moment of impact

□ Straight □ Leaning forward □ Slouching down in seat
□ Turned to the left □ Turned to the right

12. Direction body was thrown

□ Forward then backward □ Backward then forward □ To the left □ To the right
□ About the vehicle □ Outside the vehicle □ Under the vehicle

13. Head position at impact

□ Straight □ Tilted forward □ Turned to the left □ Turned to the right

14. Direction head was thrown

□ Backward then forward □ Forward then backward □ Side to side

15. Type of restraint

□ Lap belt □ Shoulder belt □ Shoulder/lap belt

16. Place patient was seated in vehicle

□ Driver □ Front passenger □ Back passenger: driver's side / middle / right side

17. Did airbags deploy?

□ Yes □ No

18. Were you seen at a medical facility following the accident?

□ No □ Yes: Name of facility: _____

Symptoms

1. Do you have lacerations, cuts, or bruising?

□ Head or face □ Neck □ Arms □ Legs □ None

Describe injuries: _____

_____

2. Head injuries (now or at the time of accident)

□ Was knocked out or unconscious

□ Headaches	□ Face pain	□ Pupils different sizes
□ Dizziness	□ Room spins (vertigo)	□ Balance problems
□ Difficulty walking	□ Very tired or fatigued	□ Sleep difficulties
□ Day dreaming	□ Disoriented/ confusion	□ Difficulty speaking
□ Attention problems	□ Memory problems	□ Hearing problems
□ Appetite changes	□ Nausea/vomiting	□ Flashbacks to accident
□ Change in sense of smell or taste		□ Visual disturbances, blurry or doubled vision
□ Changes in sexual function		□ Changes in personality

□ **Changes in Mood (a-k)**	a. Sadness	b. Agitation	c. Anger
	d. Apathy	e. Irritability	f. Frustration
	g. Impatience	h. Reduced confidence	i. Helplessness
	j. Wanting to be alone	k. Mood swings	

□ **Difficulties with (a-f):**	a. reading or writing	b. adding or subtracting	c. learning new things
	d. understanding	e. remembering numbers	f. making decisions

3. Jaw Problems

□ Jaw pain	□ Clicking	□ Pain while chewing
□ Pain while talking	□ Pain while yawning	□ Pain while moving jaw from side to side

4. Neck Injuries

□ (a- d) Neck pain, numbness, tingling, weakness that radiates or goes down:

a. in RIGHT shoulder, arm, forearm, or hand	b. in LEFT shoulder, arm, forearm, or hand
c. to RIGHT upper back	d. to LEFT upper back

□ Neck pain that causes headaches □ Neck spasms or shoulder spasms

□ Popping, clicking or clunking sounds with neck movement

5. Shoulder injuries

□ Shoulder pain	LEFT	RIGHT	BOTH
□ Shoulder pain with movement	LEFT	RIGHT	BOTH
□ Shoulder spasms	LEFT	RIGHT	BOTH

Shoulder pain is (a-e):	a. Sharp	b. Dull	c. Achy
	d. Pins and needles	e. Shoulder pain that radiates or shoots into arm	

6. Upper arm pain: LEFT RIGHT BOTH

□ Dull □ Ache □ Sharp □ Stabbing □ Burning

7. Elbow pain: LEFT RIGHT BOTH

□ Dull □ Ache □ Sharp □ Stabbing □ Burning

8. Forearm pain: LEFT RIGHT BOTH

□ Dull □ Ache □ Sharp □ Stabbing □ Burning

9. Wrist pain: LEFT RIGHT BOTH

□ Dull □ Ache □ Sharp □ Stabbing □ Burning

10. Hand pain: LEFT RIGHT BOTH

□ Dull □ Ache □ Sharp □ Stabbing □ Burning

11. Mid back pain or upper back pain

□ Dull □ Ache □ Sharp □ Stabbing □ Burning

12. Lower back pain

□ (a-b) Low back pain, numbness, tingling, weakness that radiates or goes down to the buttock, thigh, leg, or foot: a. RIGHT SIDE b. LEFT SIDE

□ Low back spasms

13. Pelvic or sacral pain

□ (a-b) Pelvic pain, numbness, tingling, weakness that radiates or goes down to the buttock, thigh, leg, or foot a. RIGHT SIDE b. LEFT SIDE

□ Sacral pain (tailbone)

14. Hip pain: RIGHT LEFT BOTH

□ pain is localized

□ pain, numbness, tingling that radiates or goes down to buttock, thigh, leg, or foot

15. Upper leg pain: RIGHT LEFT BOTH

□ Upper leg pain that radiates to knee □ Upper leg spasms

16. Knee pain: RIGHT LEFT BOTH

Knee pain that radiates to: □ calf □ calf and ankle □ calf, ankle, and foot

17. Ankle pain: RIGHT LEFT BOTH

□. Ankle pain that radiates to foot □ Ankle and foot pain

18. Foot pain: RIGHT LEFT BOTH

19. Chest pain: YES NO

20. Stomach pain: YES NO

21. Other pain related to accident: _____

_____

_____

_____

Personal Injury Case Patient Responsibility Policies

Your full understanding of, and agreement to, all our policies listed below prior to taking on any Personal Injury Case is required. Please read this document carefully and be sure to ask any questions you might have before signing. (*Please request a copy of this signed document for your own records if such is desired.)*

Patient Responsibilities and Billing Policy: As a Personal Injury Case Patient seeking services from Bent Chiropractic it is your responsibility to:

- **Keep all scheduled appointments and/or cancel any appointments 24 hours prior**
- **Follow and actively participate in the recommendations and care plans provided**
- **Fully understand that you (the undersigned) agree to pay the full amount due** for all care provided relating to your personal injury case **if your case is not covered for any reason** by the insurance company and/or your attorney refuses to pay your balance due

Appointment Scheduling/Cancellation/No Show Policy: You may be subject to a **Missed Appointment Fee** of **$40.00** for any missed or no-show appointment. Two missed/no-show appointments may result in termination from our practice.

An appointment is considered a Missed Appointment if:

- You are a **No Show/No Call** -or- We do not receive **a 24-hour cancellation notice**
- We do not receive **a 1-hour notice for cancellation of same-day sick appointments**.
- Late arrival for an appointment resulting in an appointment reschedule

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Patient acknowledgement and agreement of above policies:

I, _____ fully acknowledge and agree to all the policies stated above pertaining to my Personal Injury case and agree to pay in full the balance due for all care related to my Personal Injury case should the event arise that compensation for all care isn't provided by the insurance company/ my attorney.

Patient's Name (Please Print)_____

Signature of Patient or Guardian _____

Print Name/Relationship to Patient _____

Date_____/_____/_____