PROGRESSIVE
SPINE & REHAB CENTER

MOTOR VEHICLE ACCIDENT PATIENT FORM

Please answer all the questions completely. All information provided is strictly confidential.
If you do not understand a question or are unsure of the information, please ask for assistance.

Patient Name: _____ Date: _____

Date of Injury: _____ Time of Injury:_____ ❑ AM ❑ PM
City where crash occurred: _____
Street (location) where accident occurred: _____
Who owns the vehicle you were involved in? _____

Did the police come to the accident scene? ❑ Yes ❑ No
Did the police make a written report? ❑ Yes ❑ No
If yes, report number if known: _____

Do you have automobile medical insurance coverage? ❑ Yes ❑ No
Company Name: _____ Phone: _____
Address: _____ City:_____
State: _____ Zip:_____
Have you reported this injury to your car insurance company? ❑ Yes ❑ No
Adjuster's Name: _____ Phone: _____
Policy #: _____ Claim #: _____

Is an attorney representing you? ❑ Yes ❑ No
Name: _____ Phone: _____
Address: _____ City:_____
State: _____ Zip:_____

Have you been able to work since the injury? ❑ Yes ❑ No
Have you lost days off work? If yes, you were off work: ❑ Partially ❑ Completely
Please list all dates off work: From:_____ To:_____

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DESCRIBE HOW THE CRASH HAPPENED:

_____

_____

_____

Was the street wet or dry? ❑Wet ❑Dry

DESCRIBE THE VEHICLE YOU WERE IN:

Make:_____ Model:_____

At the time of impact your vehicle was:

❑ Slowing down ❑ Gaining speed ❑ Unknown speed ❑ Stopped ❑ Moving at steady speed

DESCRIBE THE OTHER VEHICLE:

Make:_____ Model:_____ ❑ unknown

At the time of impact the other vehicle was:

❑ Slowing down ❑ Gaining speed ❑ Unknown speed ❑ Stopped ❑ Moving at steady speed

INDICATE ANY VEHICLE DAMAGED TO YOUR CAR:

_____

_____

ALL TYPES OF COLLISIONS (Indicate those relevant to your case):

❑ Was the door(s) of your vehicle damaged to a point where you could not open the door?
❑ Did an airbag deploy in your vehicle during the crash?
❑ Were you intoxicated (alcohol) at the time of the crash?

SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT:

❑ Were you wearing a seatbelt?
If yes: ❑ Lap and shoulder strap, ❑ Lap belt only
❑ Were you holding onto the steering wheel (driver only) at the time of impact?
If yes, indicate where each hand was positioned (Use time clock face as your reference point)
Left hand: ❑ Not on wheel, ❑ Yes, hand at ___o'clock, ❑ Hand elsewhere
Right hand: ❑ Not on wheel, ❑ Yes, hand at ___o'clock, ❑ Hand elsewhere

AWARENESS AND BODY POSITION DESCRIPTIONS:

❑ You were **unaware** of the impending collision.
❑ You were **aware** of the impending crash and relaxed before the collision.
❑ You were **aware** of the impending crash and braced yourself.
❑Your body, torso, and head were facing straight ahead.
❑ You had your head and/or torso turned at the time of collision: ❑ Turned to the left, ❑ Turned to the right
❑ You were leaning forward at the time of impact resulting in a gap between your body and the seatback.
❑ Your torso and body was positioned normally against the seatback with no gaps due to leaning/twisting.

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BRUISING, CUTS, BURNS AFTER THE CRASH:

❑ Did your body have any bruising, cuts or burns after the crash? If yes indicate where: _____
_____

HOW SOON DID YOU FIRST NOTICE ANY PAIN OR SORENESS AFTER YOU YOUR INJURY?:

❑ Less than 24 hours after injury ❑ Began 1-7 days after injury ❑ Began ___ days after injury

POST-TRAUMATIC SYMPTOM QUESTIONNAIRE

Place a check mark in the appropriate columns for the specific symptom which applies to you.

SYMPTOM LIST	BEGAN UNDER 24 HOURS	BEGAN 1 TO 7 DAYS AFTER INJURY	SYMPTOMS YOU HAVE CURRENTLY	HAD SIMILAR SYMPTOMS WITHIN ONE YEAR
Headache/migraine				
Dizziness				
Tinnitus (ear ringing)				
Blurry vision				
Memory problems				
Poor concentration				
Irritability				
Balance problems				
Loss of coordination				
Sensitivity to sound				
Sensitivity to light				
Fatigue				
Anxiety				
Pain/difficulty swallowing				
Jaw pain/soreness				
Neck pain/soreness/aching				
Neck stiffness				
Shoulder pain/stiffness				
Arm pain/tingling/numbness				
Wrist/hand/finger pain/numbness				
Weakness in arms/legs				
Upper/middle back pain/soreness				
Rib cage pain				
Low back pain/soreness/aching				
Hip pain				
Leg pain				
Leg numbness/tingling				
Pain shoots down back of leg				
Knee pain				
Ankle/foot pain				

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EMERGENCY ROOM DATES:

❑ Did you go to the emergency room afterward? If yes, date and time:_____
Name of the emergency room?_____City: _____

❑ Were you hospitalized after being seen in Emergency Room?
If yes, how many days: _____

❑ Did the emergency room doctor take **X-rays**? Check what regions x-rays were taken:

❑ Skull/Face x-rays
❑ Neck or Middle back x-rays
❑ Low back or Hip/Pelvis x-rays
❑ Leg or Foot
❑ Ribs/Chest
❑ Collar bone
❑ Shoulder, Arm or Hand
❑ Other

❑ Did the hospital or clinic take **MRI** or **CT** of your body? If yes, indicate where taken:

❑ Skull ❑ Neck ❑ Low back or hip/pelvis ❑ Other

❑ Did you have any broken bones/fracture/dislocations/herniated or bulging discs? If yes, where:

_____

❑ Did the ER doctor give you any muscle relaxants, pain medication or other prescriptions? If yes what:

_____

❑ Did you require any surgery after the accident? If yes, describe type and date: _____

PROVIDERS SEEN SINCE INJURY OR WHEN CONDITION BEGAN:

(1) Name of Hospital/Doctor/Therapist/Center: Date:

Indicate what was done:

❑ Exam-consultation or IME	❑ Chiropractic	❑ Physical Therapy
❑ X-ray Neck/Upper body	❑ Ultrasound	❑ Acupuncture
❑ X-ray Back/Lower body	❑ Injection(s)	❑ Muscle Stimulation
❑ MRI/CT scan	❑ Massage/Myotherapy	❑ Collar/Splint/Brace
❑ EMG/ Nerve conduction study	❑ Anti-inflammatory medications	❑ Heat/Ice packs
❑ Other tests	❑ Pain Medications	❑ Muscle relaxants

Indicate if treatment with this provider: ❑ Helped ❑ Did not help ❑ Other

(2) Name of Hospital/Doctor/Therapist/Center: Date:

Indicate what was done:

❑ Exam-consultation or IME	❑ Chiropractic	❑ Physical Therapy
❑ X-ray Neck/Upper body	❑ Ultrasound	❑ Acupuncture
❑ X-ray Back/Lower body	❑ Injection(s)	❑ Muscle Stimulation
❑ MRI/CT scan	❑ Massage/Myotherapy	❑ Collar/Splint/Brace
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Acknowledgement and Understandings

In the state of New Hampshire, RSA 264:16,III, "Medical payments coverage shall not be assignable to any health care provider". This means, if you are using medical payment coverage (MedPay) to pay for your treatment, reimbursement checks will be mailed and assigned to the policy holder, NOT the treating clinic. For this reason we recommend the following payment options: *(initial next to the payment option you choose)*

1. Hire an attorney to help with payments. Your attorney will ensure proper payment for all _____ your medical bills; either delivering MedPay payments personally or paying after settlement has been reached. Your attorney must sign a Lien Agreement prior to your second visit.

2. Use your private health insurance. You are allowed to use your health insurance as you _____ see fit. MedPay will then reimburse you for any payments made (copay, co-insurance, deductible, etc.).

3. Pay for services out-of-pocket. We promptly send claims to the auto insurance covering _____ your treatment, and reimbursement checks will be sent to you from your auto insurance carrier. This option entitles you to a 10% time of service discount.

I hereby acknowledge that I am receiving (or am about to receive) healthcare services at Progressive Spine & Rehab Center and that I have been advised that the doctor(s) providing the services is (are) willing to wait for payment for these services, provided there continues to be reasonable certainty that payment will be made either by insurance proceeds or out of the settlement of liability. In considering the amount of medical expenses to be incurred, I, the undersigned, have chosen the Initialed payment option above and hereby assign and convey directly to Progressive Spine & Rehab Center all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for payment of services rendered by the doctor(s) at Progressive Spine & Rehab Center regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or health care plan any claim insurance reimbursement and/or any applicable remedies. This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original. I have read and fully understand this agreement.

Patient's Signature: _____Date _____/_____/_____

Patient's Name: _____

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Lien Agreement

I authorize and direct my attorney_____ and any successor or associated attorneys to withhold such sums equal to my outstanding balance at Progressive Spine & Rehab Center, LLC from any structured settlement, settlement, judgment, verdict or arbitration award which I may receive, as may be necessary to protect said medical providers.

I give lien on my case stemming from my accident on _____/_____/_____ to Progressive Spine & Rehab Center, LLC against any and all proceeds on any claim, settlement, structured settlement, judgment, verdict or arbitration award which may be paid to you, my attorney, and/or myself, or monies paid from any insurance carrier, as a result of the injuries I sustained in the accident of _____/_____/_____.

This authorization to withhold sums equal to my outstanding balance and to grant a lien to Progressive Spine & Rehab Center, LLC on my accident case applies both to claims against third parties and to claims against my own, or any other, insurance coverage, including but not limited to so called bodily to others, optional bodily injuries to others, uninsured and underinsured motorist benefits coverage, Personal Injury Protection benefits, optional medical payment benefits and disability insurance.

I completely understand that I am personally and fully responsible to Progressive Spine & Rehab Center, LLC for all bills incurred by me for treatment rendered even if an insurance company responsible for payment refuses to pay my bills or when available benefits are exhausted. I realize that buy signing this Lien form I am doing so only for Progressive Spine & Rehab Center, LLC's additional protection. I also understand that full payment for all outstanding medical bills does not depend on any claim, settlement, judgment, verdict, or arbitration award which I may recover.

Patient's Signature: _____Date _____/_____/_____

I hereby instruct my current attorney to immediately sign this form below upon receipt and return it signed to Progressive Spine & Rehab Center, LLC. A failure to sign this lien as instructed and promptly return it is a violation of our attorney client relationship and interference in my doctor patient relationship.

Patient's Signature: _____Date _____/_____/_____

The undersigned being attorney of record for the above patient herby agrees to observe all of the terms of the above agreement. I further agree to promptly forward all PIP and Med Pay payments received directly to Progressive Spine & Rehab Center, LLC.

Attorney's Signature: _____Date _____/_____/_____

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