GEORGIA
SPINE & SPORTS
REHAB

Auto Accident Intake Form

Name:_____ Date of Birth: _____/_____/_____

Sex: M___ or F_____ SS#:_____-____-_____

Address:_____ City:_____ State:_____ Zip:_____

Cell Phone:_____ Email Address:_____

Emergency Contact:_____ Relation:_____

Contact number:_____

Who referred you to the practice:_____

Check (x) all symptoms you currently have or have had in the past year

General: ☐ Chills ☐ Depression / low mood ☐ Dizziness ☐ Fainting / passing out
☐ Fever ☐ Forgetfulness / memory issues ☐ Headache
☐ Loss of sleep / insomnia ☐ Unintentional weight loss
☐ Nervousness / anxiety ☐ Numbness / tingling
☐ Sweats (daytime or night)

Muscle/Joint/Bone Pain, Weakness, numbness in: ☐ Arms ☐ Back ☐ Feet ☐ Hands ☐ Hips ☐ Legs ☐ Neck ☐ Shoulders

Genito-urinary: ☐ Blood in urine ☐ Frequent urination ☐ Lack of bladder control ☐ Painful urination

Gastro-Intestinal: ☐ Poor Appetite ☐ Bloating ☐ Bowel Changes ☐ Constipation ☐ Diarrhea ☐ Excessive Hunger ☐ Excessive thirst ☐ Hemorrhoids ☐ Indigestion ☐ Nausea ☐ Rectal Bleeding ☐ Stomach Pain ☐ Vomiting

Skin: ☐ Bruise Easily ☐ Hives ☐ Itching ☐ Changes in moles ☐ Rash ☐ Scars ☐ Sores that don't heal

Cardio-Vascular: ☐ Chest Pain ☐ High Blood Pressure ☐ Irregular Heartbeat

☐ Low Blood pressure ☐ Poor Circulation ☐ Rapid Heartbeat ☐ Swelling of ankles

☐ Varicose Veins ☐ History of blood clotting

Men Only: ☐ Erection Difficulties ☐ Lump in testicles ☐ Penis Discharge ☐ Sore on Penis

Women Only: ☐ Abnormal Pap Smear ☐ Bleeding between periods ☐ Breast Lump

☐ Extreme Menstrual Pain ☐ Hot Flashes ☐ Nipple Discharge ☐ Painful intercourse

Are you currently pregnant? ☐ Yes ☐ No Number of Children:_____

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Check (x) all symptoms you currently have or have had in the past year

Conditions: ☐ AIDS ☐ Alcoholism ☐ Anemia ☐ Anorexia ☐ Appendicitis ☐ Arthritis

☐ Asthma ☐ Bleeding Disorders ☐ Breast Lump ☐ Bronchitis ☐ Bulimia ☐ Cancer

☐ Cataracts ☐ Chemical Dependency ☐ Chicken Pox ☐ Diabetes ☐ Emphysema

☐ Epilepsy ☐ Glaucoma ☐ Goiter ☐ Gonorrhea ☐ Gout ☐ Heart Disease ☐ Hepatitis

☐ Hernia ☐ Herpes ☐ High Cholesterol ☐ HIV Positive ☐ Kidney Disease ☐ Liver Disease

☐ Measles ☐ Migraines ☐ Miscarriage ☐ Mononucleosis ☐ Multiple Sclerosis

☐ Mumps ☐ Pace Maker ☐ Pneumonia ☐ Polio ☐ Prostate Problems

Current complaints:

Mark any of the symptoms below you have noticed since the accident

☐ Arm or Shoulder Pain ☐ Back Pain ☐ Back Stiffness ☐ Chest Pain ☐ Dizziness

☐ Ear Buzzing ☐ Ear Ringing ☐ Fatigue ☐ Feet or Toe Numbness ☐ Hand or Finger Numbness ☐ Headaches ☐ Irritability ☐ Jaw Problems ☐ Leg Pain ☐ Nausea

☐Memory Problems ☐ Neck Pain ☐ Stiff Neck ☐ Shortness of Breath ☐ Difficulty Sleeping

☐ Upset Stomach ☐ Tension ☐ Blurred Vision

Occupational Information:

Movements that are painful to preform: ☐ Sitting ☐ Standing, how long? ____

☐ Lifting, how much? _____ ☐ Bending ☐ Twisting ☐ Turning ☐ Stooping

Have you been able to work since this injury? ☐ Yes ☐ No

If no how many days have you missed? _____

SPECIFIC AREAS OF COMPLAINT

1. Body Part: _____ Date symptom first appeared: ___/___/___
   How often do you experience these symptoms? Constant 100% ☐ Frequent 75% ☐ Intermittent 50% ☐ Occasional 25% ☐
   What makes these symptoms increase? _____
   What makes these symptoms decrease? _____
   Types of pain? ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Throbbing ☐ Numbness
   Please rate the intensity of your symptoms (0 being no pain, 10 being extreme) _____/10
   If pain radiates, where does it radiate to? _____

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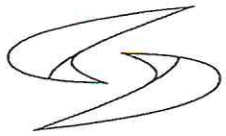

2. Body Part: _____ Date symptom first appeared: ___/___/___
How often do you experience these symptoms? Constant 100% ☐ Frequent 75% ☐ Intermittent 50% ☐ Occasional 25% ☐
What makes these symptoms increase? _____
What makes these symptoms decrease? _____
Types of pain? ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Throbbing ☐ Numbness
Please rate the intensity of your symptoms (0 being no pain, 10 being extreme) _____/10
If pain radiates, where does it radiate to? _____

3. Body Part: _____ Date symptom first appeared: ___/___/___
How often do you experience these symptoms? Constant 100% ☐ Frequent 75% ☐ Intermittent 50% ☐ Occasional 25% ☐
What makes these symptoms increase? _____
What makes these symptoms decrease? _____
Types of pain? ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Throbbing ☐ Numbness
Please rate the intensity of your symptoms (0 being no pain, 10 being extreme) _____/10
If pain radiates, where does it radiate to? _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change of health.

Date:____/_____/_____

Signature of Patient, Guardian, or personal representative: _____

Accident Information

Date of accident: _____/_____/_____ Time of accident :_____AM/PM ☐ Daylight ☐ Dawn ☐ Dusk ☐Dark

Road Conditions at the time of the accident: ☐Wet ☐Dry ☐Snow ☐Ice ☐Other:_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

Were you aware of the approaching collision prior to the impact or were you surprised? ☐Aware ☐ Surprised

Direction of Impact: ☐ Front ☐ Rear ☐ Left ☐ Right

Did you lose consciousness upon impact? ☐Yes ☐No

Did you experience a flash of light or an 'explosion' in your head? ☐Yes ☐No

Did the police come to the scene of the accident? ☐Yes ☐No

Was a traffic violation issued? ☐Yes ☐No If yes to whom? _____

Were you wearing a seat belt? ☐Yes ☐No, If yes did you experience any injury or bruising from the seatbelt ☐Yes ☐ No

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Did your head hit the headrest during the accident? ☐Yes ☐ No, If yes was the position of the headrest altered? ☐Yes ☐No

Did you have a hat or glasses on? ☐Yes ☐No, If yes were they still on after impact? ☐Yes ☐No

Did your car impact another vehicle? ☐Yes ☐No

Did your car impact a structure? ☐Yes ☐No If yes please explain: _____

Did the airbag deploy? ☐Yes ☐No If yes, did it strike you?_____ If yes, where?_____

Which way was your head pointing at the time of the impact? ☐Straight ☐Left ☐Right

Where were your hands? ☐One on the wheel ☐Both on the wheel ☐Other

Did you go to the hospital? ☐Yes ☐No If yes when?_____ How did you get to the hospital?_____ Did the hospital do anything for your injuries?_____

Name of the hospital:_____

YOUR VEHICLE

Please list the year, make and model of the car you were in: Year _____ Make _____ Model _____

Was your car stopped at the time of impact? ☐ Yes ☐No If yes, was the driver's foot on the brake ☐Yes ☐No If no, estimated speed of your vehicle _____, if vehicle was moving at the time of impact, was it ☐Slowing Down ☐Gaining Speed ☐Steady Speed

OTHER VEHICLE

Please list the year, make and model of the car they were in: Year ___ Make _____ Model _____

Was the car stopped at the time of impact? ☐Yes ☐No If no, estimated speed of their vehicle ____, if vehicle was moving at the time of impact, was it ☐Slowing Down ☐Gaining Speed ☐Steady Speed

LIFESTYLE INFORMATION

Do you smoke? ☐Yes ☐No if yes, how many packs a week? _____Do you consume alcohol? ☐Yes ☐No if yes, how many drinks a day? ____

Do you exercise? ☐Yes ☐No If yes, how many times per week? _____, what type? _____

Do you have a high stress level? ☐Yes ☐No If yes, please list reasons

_____

Please list any medications, vitamins, or supplements you are currently taking:

_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change of health.

Signature of Patient, Guardian, or personal representative: _____

Date:____/_____/_____

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AUTOMOBILE INSURANCE INFORMATION

Driver's name of the vehicle you were in: _____
Name of their automobile insurance: _____
Policy #_____ Claim #_____
Name of claims adjuster: _____
Claims adjuster's phone number and/or email address _____

Driver's name of the ***other*** vehicle: _____
Name of their automobile insurance: _____
Policy #_____ Claim #_____
Name of claims adjuster: _____
Claims adjuster's phone number and/or email address _____
Do you have an attorney? ☐Yes ☐No

Attorney Name: _____

Contact: _____

Phone: _____ Fax: _____

Do you have Medpay? ☐Yes ☐No If yes so, List amount of Medpay: $ _____

ACCIDENT LIABILITY POLICY

1. I understand I am being treated for injuries sustained in a motor vehicle accident/personal injury accident. Failure to keep my appointment may jeopardize the insurance carrier's responsibility for medical costs and/or compensation for pain and suffering.
2. I understand this office is extending me credit for treatment. If I miss three office visits, all bills will be due immediately and a **$55 missed appointment fee will be incurred for each missed appointment.** Initials___
3. I understand if I sever ties with my attorney before settlement or my attorney will no longer represent my case, all bills will be due immediately. Initials___
4. You as a patient are expected by insurance carriers and/or attorneys to follow the treatment plan given by the doctor. Failing to do so can jeopardize your case with your attorney and/or your claim with said motor vehicle accident insurance.

Patient Signature_____ Date_____

FINANCIAL POLICY

1. ACCOUNTS THAT HAVE NOT RECEIVED ANY PAYMENTS FOR 3 MONTHS WILL BE REFERRED TO A COLLECTION AGENCY. ADDITIONALLY, A COLLECTION FEE MAY BE ASSESSED ON THE BALANCE.
2. PATIENT'S MEDICAL RECORDS ARE THE PROPERTY OF GEORGIA SPINE AND SPORTS REHAB. ANY PATIENT REQUESTING A COPY OF THEIR MEDICAL RECORD WILL BE CHARGED A FEE THAT FOLLOWS THE GUIDELINES SET BY GEORGIA STATE MANDATE.
3. ALL INSUFFICIENT FUND CHECKS WILL BE CHARGED A $25.00 FEE.
4. APPOINTMENT CANCELLATION FEE **IS $55.00 FOR ALL APPOINTMENTS CANCELED WITH LESS THAN 24 HOURS NOTICE OR MISSED APPOINTMENTS. _____Initials**
5. APPOINTMENT CANCELLATION FEE IS **$65.00 FOR DECOMPRESSION APPOINTMENTS CANCELED WITH LESS THAN 24 HOURS NOTICE OR MISSED APPOINTMENTS. _____Initials**
6. IF A PATIENT IS GOING TO BE MORE THAN 15 MINUTES LATE TO AN APPOINTMENT, THEY MUST CALL TO LET THE OFFICE KNOW IN ORDER TO KEEP THEIR APPOINTMENT FOR THE DAY. _____**Initials**

I hereby give consent for the above-named doctors to treat me. This may or may not include the need for x-rays. If x-rays are needed, the doctor will inform me first. I also hereby assign to the above-named doctors all benefit payments provided by my health insurance company, auto insurance company or a settlement from my attorney for services described. I give Georgia Spine and Sports Rehab permission to treat me in an open room with other patients. I am aware other people may overhear some of my health information. I authorize the release of any medical or other information necessary to process my insurance claim or pending legal case. I acknowledge that I have been informed of Georgia Spine and Sports Rehab financial and HIPAA policy.

Signature of Patient/Responsible _____ **Date:**_____/_____/_____

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Medical Information Release Form

(HIPAA Release Form)

HIPAA Compliance Patient Consent Form Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that: Protected health information may be disclosed or used for treatment, payment, or healthcare operations. The practice reserves the right to change the privacy policy as allowed by law. The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions. The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐Yes ☐No

May we leave a message on your answering machine at home or on your cell phone? ☐Yes ☐No

May we discuss your medical condition with any member of your family? ☐Yes ☐No If Yes, please name the members allowed with their relation to you:

_____

_____

This consent was signed by: _____ (PRINT NAME)

Signature: _____

Date: _____

Witness: _____

Date: _____

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4325 South Lee Street Buford, Georgia 30518

Ph:770-614-6551 Fax: 770-831-5435

Personal Injury Office Policy

A personal injury case is any case in which a person was injured due to the fault of another person (this does not include work injuries in most cases). Automobile accidents are an example of a personal injury case. If you were involved in an automotive accident and have **PIP/MED PAY INSURANCE COVERAGE** we will ask you to open that PIP/MED PAY coverage to pay the bills at our office. **THIS MUST BE DONE IMMEDIATELY.** If you do not have PIP/MED PAY on your insurance policy, we require that you either hire an attorney or pay in full for each visit. By signing below you are authorizing us to release your records to an attorney or appropriate third parties in order for us to collect on the balance due for your accident claim.

Our office will do our very best to ensure that you receive the best possible care. However, this will require active participation between yourself and the doctor. You will need to adhere to the treatment schedule that the doctor prescribes for you. If you miss an appointment and do not call us to tell us ahead of time you will charged for that appointment.

If this is a third-party claim, we will be filing a lien with the municipality. There is a $22.00 per year filing charge that will be added to your account.

If you have PIP/MED PAY insurance and the insurance company is not paying in full or you have exhausted your benefits a lien will be filed with the municipality and the $22.00 per year fee will be charged to your account.

Once the claim has settled no further liens will be filed.

I, _____, have read, understand and agree to the above policy.

Signed _____

Date _____

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Notice of Doctor's Lien

To ATTORNEY:_____

Dr. Joseph Krzemien & Dr. Corinna Terwilliger
4325 South Lee Street
Buford, GA 30518
Phone: 770-614-6551
Fax: 770-831-5435

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved. I hereby authorize and direct you, my attorney, to pay to said doctor such sums as may be due and owing him/her for medical services rendered me by reason of this accident and by reason of any other bills that are due his/her office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or in connection therewith. I agree never to rescind this document and that rescission to said doctor will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honored by my attorney, I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her. I fully understand that I am directly and fully responsible to said doctor for all medical and/or surgical benefits, including major medical, submitted by him/her for services rendered me and that this agreement is made solely for said doctor's additional protection. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I eventually recover said fee. If this account is assigned for collection and/or suit, collection costs and/or interest, and/or attorney fees, and/or court costs will be added to the total amount due. Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Date: _____/_____/_____
Patient's Name (printed): _____
Patient DOB:_____/_____/_____
SSN:_____-_____-_____
Date of Accident: _____/_____/_____
Patient's Signature: _____
Witness:_____

ACKNOWLEDGEMENT OF ATTORNEY

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict out of monies otherwise not payable to and as may be necessary to adequately protect said doctor named. Any settlement of this claim without .honoring this assignment/lien will cause you to be responsible to this office for payment. The prevailing party in any litigation resulting from enforcement of this lien shall be entitled to actual attorney's fees and court costs.
Date: _____/_____/_____
Attorney's Signature:_____

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LETTER OF REPRESENTATION

Patient Name: _____

Date of accident: ____/____/____

Attorney Name: _____

The above-named patient is being treated by our office for injuries sustained in an automobile accident. Our patient has informed us that you are representing him/her in his/her case. We would like to confirm that you are representing our patient so that we may forward medical records and billing appropriately.

Please check the appropriate box below and fax to 770-831-5435 or email to office@georgiaspinesports.com

☐ Yes, I am representing the above patient.

☐ No, I am not representing the above patient.

☐ Other, please explain _____

Attorney Signature _____

Thank you,

Georgia Spine and Sports Rehab