PERSONAL INJURY QUESTIONNAIRE

Name________________________________ Age______ DOB__________ Sex M F

Address______________________________ City______________ State______ Zip______

Phone ( )______________ Work/Cell ( )______________ SS#:______________

Occupation______________ Employer______________ Spouse______________

Emergency contact name______________________________ Tel #______________

Name of your Auto Insurance______________________ Policy#______________

Responsible Parties Name______________________ & Insurance Co. Name______________

Has the third party accepted liability? ( ) Yes ( ) No ( ) Not sure yet

Attorney Name:______________________ Phone#______________

NATURE OF ACCIDENT:

1. Date of Accident______________ Time of Day__________
2. Were you: ( ) Driver ( )Passenger 3. Number of people in vehicle:______
4. Location of accident (street, intersection, city, state, etc)______________________
5. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
6. Approximate speed of your car____mph Other car ____mph
7. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long?______________
8. Were police notified? ( ) Yes ( ) No Was a police report filed? ( ) Yes ( ) No
   If yes, please provide our office with a COPY.
9. In your own words, please describe the accident:______________________________
____
____
10. Did you have any physical complaints BEFORE the accident? ( ) Yes ( ) No If yes, please describe:
____
11. Please describe how you felt:
    a) DURING the accident:______________________________
    b) IMMEDIATELY AFTER the accident:______________________________
    c) LATER THAT DAY:______________________________
    d) The NEXT DAY:______________________________
12. What are your PRESENT complaints and symptoms______________________________
13. Do you have any previous illness' which relate to this case or were worsened by this accident? If so, describe:______________________________

OVER

14. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe, including dates and types of accident and injuries received:____________________

____

15. Where did you go immediately after the accident? (hospital, home, Doctors office)?________________

____

16. Have you seen any other Doctors since the accident? If yes, please list Doctors name:________________

____

What type of treatment did you receive?____________________ Any medications?________________

____

17. Since this accident occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

18. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

( ) Headache	( ) Irritability	( ) Numbness in Toes	( ) Face Flushed	( ) Feet cold
( ) Neck Pain	( ) Chest Pain	( ) Shortness of Breath	( ) Buzzing in Ears	( ) Hands cold
( ) Neck Stiff	( ) Dizziness	( ) Fatigue	( ) Loss of Balance	( ) Fainting
( ) Stomach Upset	( ) Back Pain	( ) Sleeping Problems	( ) Depression	( ) Fever
( ) Nervousness	( ) Cold Sweats	( ) Light bothers eyes	( ) Loss of Smell	( ) Tension
( ) Numbness in fingers		( ) Pins & Needles in Arms	( ) Pins & Needles in Legs	

Other:____

19. Have you lost time from work as a result of this accident? ( ) Yes ( ) No

20. List any activities you cannot do as a result of this injury: ____________________

____

21. Other pertinent information the Doctor should know that was not addressed in this questionnaire:

____

____

________________ __________________________

Date **Patient Signature**

NOTICE OF DOCTOR'S LIEN

TO: Attorney______________________

____

____

FROM:

Dr. F. Scott Sebastian, D.C.
Leucadia Chiropractic
280 N. Coast Hwy 101
Encinitas, CA 92024
(760) 942-3321 FAX (760) 942-4468

RE: Medical Reports and Doctor's Lien DOI:____________

I do hereby authorize the above Doctor to furnish you, my Attorney, with a full report of his 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 for medical service rendered me by reason of this accident and by reason of any other bills that are due his 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 injuries in connection herewith.

I agree never to rescind this document and that a rescission will not be 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.

I fully understand that I am directly and fully responsible to said Doctor for all medical benefits submitted by him for service 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 may 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 Doctor's office. I have been advised that if my Attorney does not wish to cooperate in protecting the Doctor's interest, the Doctor will not await payment but may declare the entire balance due and payable. Also, upon settlement of this case, I instruct you, my Attorney, to provide said Doctor all medical records, billing from other providers, settlement amounts from insurance companies and third party individuals and the proposed settlement split between all parties, upon their request. This information will be used solely for the purpose of the settlement negotiation for this case.

Dated:______________________ Patient's Signature:______________________

Witness:______________________ Print Patient's Name:______________________

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 as may be necessary to adequately protect said Doctor above 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.

Dated:______________________ Attorney's Signature:______________________

Attorney: -Please date, sign and return one copy to above Doctor's office at once.
-Keep one copy for your records

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

Patient Name:____

Insurance Company:______________________________________

I hereby instruct the above named insurance company to pay by check made out to and mailed directly to:

F. Scott Sebastian, D.C.
280 N. Coast Hwy 101
Encinitas, CA 92024
(760) 942-3321

for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy or by a 3rd party payor who would otherwise pay me directly, as payment toward the total charges for professional services rendered.
THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY AND/OR CLAIM.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by the insurance policy.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or Attorney for the purpose of securing payment under this policy of insurance.

Date:____________ Signature of Policy Holder______________________

Witness:______________

Signature of Claimant, if other than policy holder____________________________

Leucadia Chiropractic PERSONAL INJURY PAYMENT POLICY

Med-Pay Information

If you have been involved in an automobile accident, we will need a copy of your car insurance card. We will then verify if you have medical payments as part of your coverage. If you do, we will bill your car insurance for your care. If you were a passenger in someone else's car, we will need a copy of the driver's car insurance to see if they have medical payments coverage for you.

-You (or the driver) pay for this benefit and it DOES NOT increase your premiums.

-Your insurance will be *reimbursed* from the *responsible parties insurance* upon settlement of the claim. If you were at fault, your auto insurance simply pays your bills with no reimbursement to them.

-If you were hit by an uninsured motorist and you have uninsured motorist coverage, your insurance will pay for your care at the conclusion of treatment.

If you do not have medical payments coverage, or health insurance, you will need to get an attorney. This both protects you and the doctor. If you need a referral to an attorney, we will be happy to refer you to a few that we work with.

This office does NOT accept 3rd party liens. A 3rd party lien is a type of case where the other party (insurance of the person who hit you) accepts responsibility for your medical care, but DOES NOT pay us directly. They typically refuse to pay us directly citing that their responsibility is to you, the person their insured hit, not to all of the providers you saw. Since we are unable to secure a direct method of payment, we do not accept these circumstances. However, at times, a case may *default* to a 3rd party lien situation. In the event of this, the following explains how those cases are handled:

3RD Party Financial Agreement

I understand that I am to resolve my case with the Third Party payor within 3 months following the completion of my medical care, at which time, I am to pay Leucadia Chiropractic per the terms stated below. If settlement is not made within 3 months following the completion of medical care, I become personally responsible for payment of my medical bill.

TERMS: I fully understand that I am to pay Leucadia Chiropractic by cash, check, money order or cashiers check (no credit cards accepted) for any remaining balance from my Personal Injury case within 5-10 days upon receipt of my settlement check form the Third Party insurance company.

-Our office must be notified on a regular basis as to the status and progress of settlement of your claim. If, for some reason, there are extenuating circumstances that prevent you from settling within 3 months, our office should have been receiving routine updates in order to justify an extenuating circumstance.

-If a balance continues per the terms stated above, a 1 ½% interest penalty will be added to my account on a monthly basis along with any collection fees.

As with any case, if we are unable to secure payment from the auto insurance, attorney, health insurance, etc,. or they have failed to make full payment and a balance is owing, you understand that you are ultimately responsible for payment of your case out of any settlements that you receive or otherwise.

I have read and understand the Personal Injury policies of Leucadia Chiropractic.

_______________________   __________

Patient Signature   Date

Leucadia Chiropractic Clinic
F. Scott SeBastian, D.C., Q.M.E.
280 N. HWY 101
Encinitas, CA 92024

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that the Notice of Privacy Practices is posted permanently in the waiting room at Leucadia Chiropractic Clinic for anyone to review. I understand that Leucadia Chiropractic has the right to change its Notice of Privacy Practices from time to time. I may contact Leucadia Chiropractic Clinic at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I have been shown where the Notice of Privacy Practices in located in the waiting room and have been given the opportunity to review them.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ______________________________ Date: ____________________

Signature: ____

Relationship to Patient: ______________________________

LEUCADIA CHIROPRACTIC
OFFICE FEE SCHEDULE

Welcome to our office! The information below regarding our fees is provided to you to make you aware that our fees are different if you are a cash paying patient versus if you have insurance, a personal injury (auto accident) or workers compensation case.

CASH: Currently, our cash rate for an adjustment is $40.00. Co-pay and co-insurance amounts vary. These fees are also called point-of-service fees as they are paid at the time services are rendered. Understand also that this is a *discounted* fee and that our regular fees range from $95-$170.00 per visit (dependent on therapies performed including ultrasound, heat, massage, muscle stim, etc.). <u>Since this is a *discounted* rate off of our usual fees, if, at any time, you have any other coverages either through insurance, an auto accident, or workers compensation claim, please notify our office immediately so that we can make efforts to receive our regular fees.</u>

WORKERS COMPENSATION: Patients are not responsible for any costs incurred with a workers comp injury with the possible exception of supplements. You are also entitled to mileage reimbursement and our office can provide you with print outs of your visits for you to fill out the mileage paperwork provided by workers comp for you to be reimbursed.

PERSONAL INJURY: Otherwise known as auto accidents and sometimes, slip and falls.
The fees for personal injury cases range from $95-$170.00 per visit, dependent on the therapies you receive. With these slightly higher rates, extended wait time for payment is considered as is elaborate documentation of the patients care, including lengthy narrative reports, etc. Also, our charges are used by the responsible parties insurance to determine the extent of the patients need for care and are also used in calculating settlement offers to the patient. Therefore, we itemize all services performed at the visit and charge for them accordingly.

INSURANCE: If your health insurance offers coverage, we will do our best to verify your benefits and bill it in accordance with any contractual guidelines, usually these charges range from $65-150.00 dependent on the therapies you receive. All billing is done as a courtesy to you, to help offset your cost, however, there may be times when we are mis-quoted information or payment is not made as described by your insurance. These additional amounts are your responsibility and we will do our best to keep you apprised of any information regarding your benefits if they should change. You are also responsible for payment of any deductibles, co-pays, and co-insurance amounts not covered by your insurance.

CANCELLATION FEES: Please note that massage therapy cancellation requires 24-hour notice to avoid a cancellation fee of $30.00 for an hour and $15 for a ½ hour massage. Please understand that we pay the therapists for all visits not cancelled with 24-hour notice and therefore we must, in-turn, charge the patient missed appointment fees for massage only.

All fees charged at Leucadia Chiropractic are reasonable and in keeping with industry standards. We use the workers compensation fee schedule as a guideline for setting our fees, as is also typically done in the chiropractic industry.

I have read and understand the fees charged at Leucadia Chiropractic.

______________________________ ____________

Patient Signature Date

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please *circle the number* which best describes how your typical level of pain affects these six categories of activities.

1. Family/at-home responsibilities such as: yard work, chores around the house, driving kids to school, etc.-

0	1	2	3	4	5	6	7	8	9	10
completely able to function										**Totally unable to function**

2. Recreation including hobbies, sports or other leisure activities-

0	1	2	3	4	5	6	7	8	9	10
completely able to function										**Totally unable to function**

3. Social Activities including parties, theater, concerts, dining-out and attending other social functions with friends-

0	1	2	3	4	5	6	7	8	9	10
completely able to function										**Totally unable to function**

4. Employment including volunteer work and homemaking tasks-

0	1	2	3	4	5	6	7	8	9	10
completely able to function										**Totally unable to function**

5. Self-care such as taking a shower, driving or getting dressed-

0	1	2	3	4	5	6	7	8	9	10
completely able to function										**Totally unable to function**

6. Life-support activities such as eating and sleeping-

0	1	2	3	4	5	6	7	8	9	10
completely able to function										**Totally unable to function**

Patient Name:______________________________ Date:__________

Score:________