Automobile Accident Questionnaire

Complete all sections

Name _____ Today's Date _____ Accident Date _____

How much damage is there to your vehicle? _____

To the other vehicle? _____

Name of your insurance adjuster _____

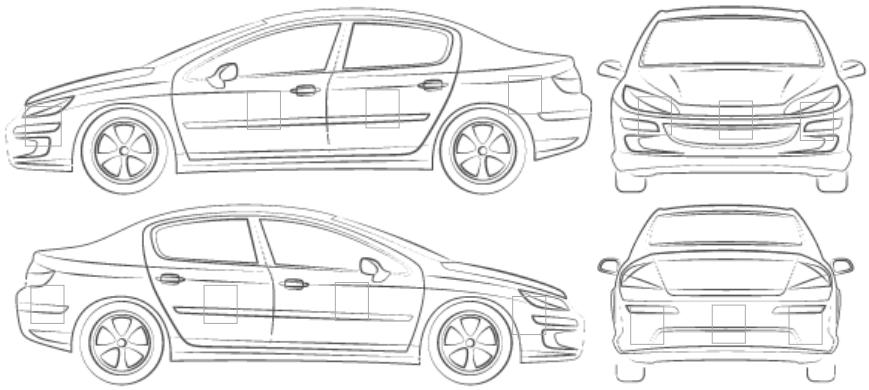
Have you retained an attorney? If so, who? _____

Before the accident:

You were driving: □North □East □South □West on _____ (St/Hwy)

Other vehicle was driving: □North □East □South □West on _____ (St/Hwy)

You were struck from: □Behind □Front □Left Side □Right Side *Mark the location on the diagram below*



Which direction was your head facing at time of impact: _____

Did your body hit any part of the car during the impact? □Yes □No If so, where? _____

You were: □driver □front passenger □back left □back right □back center

Were you wearing seat belt? □Yes □No Did the air bag(s) deploy? □Yes □No

Were you using any other protective devices? □Yes □No If yes, what? _____

Were police notified? □Yes □No Did an ambulance come? □Yes □No

Were you knocked unconscious? □Yes □No If so, how long? _____

Was alcohol or drug(s) involved? □Yes □No If so, what? _____

Where were you taken after the accident? _____

Was treatment given? □Yes □No If so, what? _____

Was x-ray taken? □Yes □No Head injury? □Yes □No Fractures? □Yes □No If so, what? _____

Pain was: □immediate □later that day □next day

Was another doctor consulted after the accident? □Yes □No

If so, what clinic? _____

What is the doctor's name? _____ The doctor is a: □D.C. □M.D. □D.O. □D.D.S.

What do you do for a living? _____

Has your job been affected and how? _____

Please list any other activities affected _____

Please list any activities that worsen your pain _____

Please list what relieves your pain (including medication) _____

Automobile Accident Questionnaire

Complete all sections

Patient Name _____ Date of Injury _____

Terms of Agreement

I hereby authorize **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)** to furnish you, my attorney, with a full report of my exam findings and treatments, etc…., in regards to the accident in which I was recently involved.

I hereby authorize and direct, my attorney, to pay **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)** such sums as may be due and owing them for all services rendered to me by reason of this accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)**. Also, I hereby allow this lien against any and all proceeds of my 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 there within.

I fully understand that I am directly and fully responsible to **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)** service rendered to me and that this agreement is made solely for their protection and in consideration of their office awaiting payment for any unpaid balance owing for services rendered to me. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover.

I agree to promptly notify **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)** of any changes or addition of attorney(s) used by me in association with this accident, and I will inform my attorney to do the same and to promptly deliver a copy of this lien to any such substitute or added attorney(s).

Please acknowledge your agreement to this request by signing below and returning it to the aforementioned provider within five (5) days of receipt. I have been advised that if you do not wish to cooperate in signing and returning this lien, **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)** will not await payment but may declare the entire balance to be immediately due and payable by me.

Patient/Guardian Signature _____ Date _____

The undersigned being attorney of record for the above patient does hereby 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 and fully compensate **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)**. Attorney further agrees to issue this payment to **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)** immediately upon settlement.

Attorney's Signature _____ Date _____

J Medical, Inc., BY: President _____ Date _____

Automobile Accident Questionnaire

Complete all sections

Consent for Treatment

I hereby authorize any physician, hospital, or medical facility to provide all information on my medical history and treatment to **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)** if necessary.

I hereby authorize **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)** to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I understand that **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)** requires physical contact.

Print Patient's Name _____

Patient/Guardian Signature _____ Date _____

Assignment of Benefits

I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY (OR MY DEPENDENTS) BEHALF I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE.

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)**. I REALIZE I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. (Deductibles, claims denied, canceled insurance etc.)

Patient/Guardian Signature _____ Date _____

Automobile Accident Questionnaire

Complete all sections

Notice of Health Information Privacy Practices

We want you to know how your Patient Protected Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Protected Health Information (PHI) we encourage you to read the HIPPA Notice that is available to you at the front desk before signing this consent.

The patient understands and agrees to allow **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)** to use their Patient Protected Health Information (PHI) for the purpose of the treatment, payment, healthcare operations, and coordination of care. For example, the patient agrees to allow **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)** to submit requested PHI to any third-party payment source, including the Health Insurance Company/Companies provided to us by the patient for the purpose of payment and any third-party who is assigned the Medical Lien in exchange for a payment to **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)**. Be assured that **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)** will limit the release of all PHI to the minimum needed for what the insurance companies require for payment. Any third-party payer who pays and of the billed charges of **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)**, covered by the medical Lien granted by the Patient may be assigned the Medical Line by **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)**.

The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions.

A patient's written consent need only be obtained one time for all subsequent care given the patient in the office(s). The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request had been presented.

For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that our records are not readily available to those who do not need them.

Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)** has the right to refuse to give care.

I have read and understand how my Patient Protected Health Information will be used and I agree to these policies and procedures. I understand that this information is subject to change without written notice.

Patient/Guardian Signature _____ Date _____

Aurora Office
12510 E Iliff Ave, Ste 210
Aurora, CO 80014
(303) 862-8853
Fax: (720) 379-5827

Thornton Office
9101 Pearl St, Ste 350
Thornton, CO 80229
(720) 328-1246
Fax: (720) 389-6543

Wheat Ridge Office
4350 Wadsworth Blvd, Ste 425
Wheat Ridge, CO 80033
(303) 564-5008
Fax: (720) 484-4329

Colorado Springs Office
2233 Academy Pl, Ste 101
Colorado Springs, CO 80909
(719) 638-4199
Fax: (719) 638-4609

Englewood Office
3333 S Bannock St, Ste 230
Englewood, CO 80110
(720) 612-7956
Fax: (888) 972-9270

Patient's Full Name

Patient's Social Security Number/Medical Record Number

Address

Patient's Date of Birth

City, State Zip Code

Patient's Telephone Number

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

_____

2. The following person (or class of persons) may receive disclosure of protected health information about me:
   Therahand Wellness Center
   His/her/Their Name
   12510 E Iliff Ave. Suite 210
   Address
   Aurora, Colorado 80014
   City, State Zip Code
3. The specific information that should be disclosed is (please give dates of service if possible):

_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
YES, DISCLOSE THIS INFORMATION *_____
NO, DO NOT DISCLOSE THIS INFORMATION * _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying Therahand Wellness Center in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for _____Continuation of Care_____
7. This authorization expires on _____, 20 ___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with HealthPort to make copies. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____	_____	_____
Signature of Individual* (The person about whom the information relates)	Date of Individual's Signature	Date of Birth or Social Security Number

OR, if applicable –

_____	_____	_____
Signature of Guardian* or Personal Representative of Patient's Estate	Date of Guardian's/Personal Representative's Signature	Description of Authority to Act for the Individual

A copy of this completed, signed and dated form must be given to the Individual or other signator.

Print Name _____ Date _____

The Rivermead Post-Concussion Symptoms Questionnaire*

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one, please circle the number closest to your answer.

0 = Not experienced at all
1 = No more of a problem
2 = A mild problem
3 = A moderate problem
4 = A severe problem

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

Headaches.....	0	1	2	3	4
Feelings of Dizziness	0	1	2	3	4
Nausea and/or Vomiting	0	1	2	3	4
Noise Sensitivity, easily upset by loud noise	0	1	2	3	4
Sleep Disturbance.....	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being Irritable, easily angered	0	1	2	3	4
Feeling Depressed or Tearful	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking Longer to Think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light Sensitivity, Easily upset by bright light.....	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties?

1._____	0	1	2	3	4
2._____	0	1	2	3	4

*King, N., Crawford, S., Wenden, F., Moss, N., and Wade, D. (1995) J. Neurology 242: 587-592