VERO
CHIROPRACTIC

Valued practice member,

Thank you for trusting our team to take care of you. In order for us to properly bill your case please provide us with the below information.

Separate Documents Needed

- Drivers License
- Your Auto Insurance Card
- Your Auto Declaration Page listing coverage
- Accident/Incident Report (Police Report)

Billing information needed for submitting your claims

- Your Auto Policy Information (if applicable)
    - Medical Adjusters Name
    - Medical Adjusters Phone number and extension
    - Medical Claim Number
    - Insurance companies Name, Claims Mailing Address & fax Number
- At-Fault Party Insurance Information
    - Medical Adjusters Name
    - Medical Adjusters Phone number and extension
    - Medical Claim Number
    - Insurance companies Name, Claims Mailing Address & fax Number
- Attorney Information (If applicable)
    - Attorney Name
    - Firm
    - Phone number
    - Fax Number

Thank you in advance for providing all of the above information so we can properly serve you.

Yours in Health,
Team Vero

Patient's Name _____ **Date of Birth** _____

VERO CHIROPRACTIC

Automobile/PI Accident or Work Comp Questionnaire

Dear Patient:
This information is considered confidential. Your answers will help us determine if chiropractic care can help your condition. We will not accept your case if we do not believe your condition will respond satisfactorily to care. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.
Thank you.

Please answer all questions completely.

Please explain in detail how your accident happened: _____
_____
_____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

List the extent of your injuries as you know them: _____
_____
_____

Were you employed at time of the crash? □ Yes □ No Are you currently employed? □ Yes □ No
If no, is your unemployment status due to the crash? □ Yes □ No
Type of work: □Office/Clerical □Light Labor □Moderate Labor □Heavy Labor

INJURY HISTORY:
Was the crash on the job? □ Yes □ No
You were: □Driver □Front seat passenger □Rear seat passenger □Motorcycle operator □Motorcycle passenger
□ Other: _____
Vehicle driven by: _____
Your vehicle year/make/model: _____
Your estimated speed at the moment of the crash:_____ □Stopped □Slowing □Accelerating
Other vehicle year/make/model: _____
Time of day: □Daylight □Dawn □Dusk □Dark
Road conditions: □Dry □Damp □Wet □Snow □Ice □Other: _____
Head restraints: □None □Integral type □Adjustable □Up □Down □Don't Know
If adjustable, was the position altered by the crash? □ Yes □ No
Was the seat back adjustment altered by the crash?□ Yes □ No
Was the seat broken? □ Yes □ No
Seat belt: □Wearing □Not wearing □Don't Know
Did the airbag deploy? □ Yes □ No If yes, were you struck? □ Yes □ No
Body position: □Good □Forward lean □Other: _____
Head position: □Forward □Left □Right □Up
Down Hand position: □One on the wheel □Two on the wheel □N/A
Brakes applied? □ Yes □ No
Were you aware of impending crash? □ Yes □ No

Patient's Name _____ Date of Birth _____

DURING THE CRASH:

Did you strike any parts of the vehicle? □ Yes □ No

If yes, describe: _____

Did the vehicle strike any objects after impact? □ Yes □ No

If yes, describe: _____

Wearing hat or glasses? □ Yes □ No If yes, were they still on after the crash? □ Yes □ No

Did you lose consciousness? □ Yes □ No If yes, for how long? _____

Estimated property damage to your vehicle: $_____

Estimated damage to other vehicle(s): □ None □ Minimal □ Moderate □ Major

Were the police on-scene? □ Yes □ No

If yes, was a report made? □ Yes □ No

Check symptoms you have noticed since the accident:

___ Headache	___ Dizziness	___ Depression	___ Fatigue
___ Light Bothers Eyes	___ Buzzing in Ears	___ Diarrhea	___ Neck Pain
___ Head Seems to Heavy	___ Memory Loss	___ Feet Cold	___ Neck Stiff
___ Pins and Needles in Arms	___ Ears Ring	___ Hands Cold	___ Fainting
___ Sleeping Problems	___ Back Pain	___ Face Flushed	___ Loss of Balance
___ Pins and Needles in Legs	___ Constipation	___ Tension	___ Nervousness
___ Numbness in Fingers	___ Loss of Smell	___ Fever	___ Irritability
___ Numbness in Toes	___ Loss of Taste	___ Chest Pain	___ Cold Sweats
___ Shortness of Breath	___ Stomach Upset		

Symptoms other than above: _____

_____

Where were you taken after the accident? _____

Hospitalized? □ Yes □ No If yes, admitted? _____ How long? _____

Name of Hospital: _____

Name of Doctor(s): _____

What treatment was given? _____

Was any other doctor consulted after your accident? □ Yes □ No

If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

What was the diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? □ Yes □ No

If so, what were the complaints? _____

Patient's Name _____ Date of Birth _____

Before the injury were you capable of working on an equal basis with others your age? □ Yes □ No

Are your work activities restricted as a result of this accident? □ Yes □ No

Since this injury are your symptoms ... □ Improving? □ Getting worse? □ Same?

Driver of other vehicle (if any):

Name _____ Insurance Company _____ Policy No. _____

Driver of vehicle in which you were injured (if applicable):

Name _____ Insurance Company _____ Policy No. _____

Name of your insurance adjustor _____

Have you retained an attorney? □ Yes □ No

If so, his/her name and address_____

You were heading North/ East/ South/ West on _____ (street or highway)

Other vehicle was heading North/ East/ South/ West on _____ (street or highway)

Were police notified? □ Yes □ No

CRASH DETAILS (In your own words)

_____
_____
_____
_____
_____
_____

CRASH DIAGRAM (From your memory)

Patient Signature _____ Date of Birth_____Date _____

Doctor Signature _____ Date _____

Patient's Name _____ **Date of Birth** _____

Office Name: **Vero Chiropractic**

Date of Accident: _____ Time of Accident:_____ City:_____ State:_____

Practice Members Medical Pay Information

Do you have Medical Pay on your Policy? YES NO
If Yes, coverage amount: $1,000 $1,500 $2,000 $2,500 $5,000 $10,000 $_____

Personal Injury Claim #: _____

Personal Injury Adjuster's Name:_____

Adjusters Phone Number: _____Extension_____

Insurance Company Name, Address & Fax Number:
_____
_____
_____

Fax Number: _____

Attorney Information

Have you retained an attorney? YES NO

Attorney Name: _____Firm: _____

Phone Number: _____Fax: _____

Lien On File? Did attorney confirm they will pay provider directly?

Other Driver (At Fault Driver) Insurance Information

Name: _____ Claim #: _____

At Fault Driver's Insurance Company Name & Address
_____
_____
_____

Personal Injury Adjuster's Name:_____

Adjusters Phone Number: _____Extension_____

At Fault States: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Idaho, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin & Wyoming

Patient's Name _____ **Date of Birth** _____

Financial Policy
Vero Chiropractic
5525 Mills Civic Pkwy. Suite 120
West Des Moines, IA 50266
Phone: 515-422-9552 Fax: 515-528-0141

It is the goal of this office to provide you with the finest quality chiropractic care available. We are committed to your care at this office. It is our desire to assist our practice members whenever possible. The following allows you, our valued practice member, to receive the care you need without undue financial strain. Below is a statement of our Financial Policy which we require you to read, initial and sign prior to services. **All practice members must complete our information and insurance form before seeing the doctor.**

_____ **(Initial here)** The privilege of insurance assignment begins when our office has qualified your insurance coverage. For your convenience, we will bill your insurance company directly and accept assignment. As always, you have the option of billing your own insurance if necessary. In a case in which you receive payment from your insurance carrier you must bring the check to the office within 5 business days of receipt and endorse it over to this office to be applied to your account. If you do not bring in payments you received directly you will receive an invoice from our office.

_____ **(Initial here)** This office does not promise that an insurance company will reimburse you for the usual and customary charges submitted by this office nor will we enter into any dispute with an insurance company over the amount of reimbursement. In the event the insurance company denies the claim, it is your responsibility to pay the charges and seek reimbursement from your insurance company.

_____ **(Initial here**) Ultimately the practice member is responsible for all services rendered including those not reimbursed by third party payors.

_____ **(Initial here)** All co-payments and deductibles must be paid when services are rendered as this office has adopted a zero balance policy. For your convenience, advance payment plans are available.

_____ **(Initial here)** Since we do not own your insurance policy and occasionally we experience difficulty in collecting from the carrier, we may ask for your active assistance in rectifying this situation after 60 days.

_____ **(Initial here** You will be sent an email, text message or US Mail for any balances over 30 days old, if this office does not hear from you within 5 days of the email, text message or US Mail you authorize this office to run your credit card that is on file for the balance on your account. If your credit card denies you understand that your account will be subject to a 1.5% interest charge per month until the balance is collected. All accounts not paid within 90 days will receive final notification and be turned over to collection agency for further action.

I have read the above, understand it fully, and agree to adhere these policies.

Practice Members Signature _____ Date_____

Witness (Team Member's sign)_____ Date_____

Patient's Name _____ **Date of Birth** _____

Vero Chiropractic
5525 Mills Civic Pkwy Suite 120
West Des Moines, IA 50266
(515)-422-9552

NOTICE OF DOCTOR'S LIEN

I hereby authorize and instruct my attorney &/or insurance carrier,_____ to pay Vero Chiropractic directly for the full amount of services rendered by Vero Chiropractic in relation to my personal injury treatment arising from my accident on or about _____ once a settlement or verdict is reached and those funds are made available or disbursed.

I understand that I am directly and fully responsible for all medical bills incurred at Vero Chiropractic for services rendered to me with respect to any personal injury treatment. Further, I understand that I am responsible for the payment of all services rendered by Vero Chiropractic, regardless of whether or not I receive any proceeds from any insurance company or third party, and that my obligation and liability to Vero Chiropractic is in no way conditioned upon any settlement of verdict.

I agree to promptly notify Vero Chiropractic of any changes in my representation or attorney for this accident.

By signing below I acknowledge and agree to this lien in favor of Vero Chiropractic the full amount owed for any and all services rendered to me by Vero Chiropractic.

I acknowledge that Vero Chiropractic is not required to permit me the option to postpone or make payments toward of services rendered, and that it is being done solely as a courtesy. As such, Vero Chiropractic may, at any time, seek payment for any and all amounts owed by me while this lien is in force. Additionally, if my attorney fails to acknowledge this lien in favor of Vero Chiropractic, the entire balance related to this personal injury treatment is my sole responsibility, and Vero Chiropractic may demand payment immediately.

_____ Print Practice Members Name

_____ Practice Member Signature

_____ Date

Acknowledged by Attorney this _____ day of _____, 20

_____ Attorney Signature