Ultra Spine Care, LLC

2811 Airline Drive, Suite 4, HoustonTexas 77009
Phone: 713-206-4631 * ultraspinecare.com

Personal Injury Questionnaire

First Name_____ Last Name_____
Nombre Apellido

Address_____ City_____ State_____Zip Code_____
Direccion Ciudad Estado Codigo postal

Phone Number_____ Alternate Number_____

Date of Birth_____ Sex_____ Social Security#_____
Fecha de nacimiento Sexo Seguro Social

Emergency Contact_____ Phone_____
En case de emergencia Telefono

Employer_____ Address and Phone_____
Empleador Direccion y telefono

Your Ins Co_____ Claim #_____
Seguro de auto

Adjuster_____ Phone_____
Ajustador Telefono

Address_____
Direccion

Have you retained an attorney? ( )yes ( )no Name: _____
Obtuvo abogado? ( )Si ( )No Nombre:

NATURE OF ACCIDENT:

Date of Accident_____ Time_____ Were you wearing your seatbelt? ( ) Yes ( )No
Fecha del accidente Hora Estaba usando su cinturon?

List the people in your vehicle: 1._____2._____

3._____ 4._____

Location of Accident: _____ Were Police Notified? ( )Yes ( )No
Lugar del accidente: Llamaron a la policia? ( )Si ( )No

What are your present complaints and symptoms? _____
Cuales son sus sintomas?

Have you ever been involved in an accident before: ( )Yes ( )No
A tenido un accidente previamente?

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In your own words, please describe how the accident happened?

En sus propias palabras, explique como el accidente occurrio?

_____

_____

Since this injury occurred, are your symptoms: ( )Improving ( )Getting worse ( )Same

Desde el accidente mis sintomas estan ( )Mejor ( )Peor ( )Igual

Do you have any health problems not listed above? _____
Tiene alguna enfernedad que no a mencionado?

Do you have any allergies? _____
Tiene Alergias?

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

A perdido tiempo de trabajo por causa del accidente? ( )Si ( )No

If yes, Please complete the following questions:

Si la respuesta es si, complete la siguiente informacion:

A. Last day worked: __/__/__

   Ultimo dia de trabajo:

B. Are you being compensated for lost time? ( )Yes ( )No

   Le estan compensando por el tiempo que no trabajo? ( ) Si ( )No

Have you noticed any activity restrictions as a result of this injury? ( )Yes ( )No

Tiene alguna restriccion en actividades? ( )Si ( )No

If yes, please describe in detail: _____

Patient Signature _____ Date_____
Firma Fecha

CONSENT TO TREAT A MINOR CHILD

I hereby authorize:

Dr. Bijan Eshkevari, D.C. and whomever he may designate as assistant to administer chiropractic care as deemed necessary to my _____, _____.

Parent/Guardian Signature_____

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Automobile Accident Description

Please answer the questions below. If you do not know the answers to any of the questions, leave it blank.

1.Your vehicle type:

__Car __Station Wagon
__ Van __Pickup Truck
__Large Truck __Bus
__Other:

2. Your position in vehicle:

__Driver __Front Passenger
__Left Rear Passenger
__Right Rear Passenger
Other:

3. What was your vehicle doing at the time of the accident:

__Stopped in intersection __Stopped in traffic __Stopped at light
__Making a right turn __Making a left turn __Parking
__Proceeding along __Slowing down __Accelerating
Other:

4. Time/Speed/Damage:

Time of accident: _____
Your vehicle's speed: ____mph
Damage to your vehicle:
__Mild __Moderate
__Totaled

5. Details of Accident:

Visibility at time of accident:
__Poor __Fair __Good
Who hit who/what?
__You hit other vehicle
__Other vehicle hit you
You hit…(object):

6. Road conditions:

Road conditions at time of accident:
__Icy __Wet __Sandy __Dark __Clean and dry

Point of Impact:
__Head – On __Left Front __Right Front
__Rear - End __Left Rear __Right Rear

7. Body Position, etc...:

Did you see accident coming? __YES __NO
Were you braced for the impact? __YES __NO
Did you have a seat belt on? __YES __NO
Did you have a shoulder harness on? __YES __NO

Does your vehicle have a headrest? __YES __NO
__Even with top of head __Even with bottom of head __Middle of neck
What was the direction of your head at the time of the impact?
__Facing straight forward __Turned to the right __Turned to the left

Did driver side airbags deploy? __YES __NO Did passenger side airbags deploy? __YES __NO Did side airbags deploy? __YES __NO

8. Additional accident Information: In case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs:

9.Durning the accident:

Did your body strike the inside of your vehicle? __YES __NO
If yes, describe:
Did you lose consciousness during the injury? __YES __NO
If yes, for how long?
Your vehicle's estimated damage?
Damage to their vehicle: __MILD __ MODERATE __TOTALED
Did police show up? __YES __NO
Was an accident report filled out? __YES __NO

10. After the accident:

Check off your symptoms right after and a few days following:
__Headache __Dizziness __Mild back pain __Cold Hands
__Neck pain __Nausea __Low back pain __Cold feet
__Neck stiffness __Confusion __Nervousness __Diarrhea
__Fainting __Fatigue __Loss of taste __Depression
__Ringing in ears __Tension __ Toe numbness __Anxious
__Loss of smell __Irritability __Constipation __Chest pain
__Pain behind eyes __Shortness of breath __Sleeping problems
OTHER:

11. Emergency Room?

Where did you go after the accident?
__Home __Work __Hospital ER __Private Doctor
How did you get there?
__Drove self __Somebody else __Ambulance __Police
Were X-rays done? __YES __NO
Was lab work done? __YES __NO
Body parts X-rayed?
What lab work?
Treatments: __Cervical Collar __Ice
Other:
Medications:
Follow-up Instructions:

12. Treatment History:

Fill in any other doctor (s) seen prior to your first visit to this office.
1.Dr. First visit date: __/__/__.
Specialty: X-ray done? __YES __NO
Types of treatments received:
How many treatments received? Currently treating? __YES __NO
Did treatments benefit you? __YES __NO
Last visit date: __/__/__.
2. Dr. First visit date: __/__/__.
Type of treatments received:
How many treatments received? Currently treating: __YES __NO
Did treatment benefit you? __YES __NO
Last visit date: __/__/__.

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Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to HOUSTON SPINE WELLNESS, PC, the following rights, power and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS AND BENEFITS: You are assigned the exclusive, irrevocable right to any benefit that exists in my favor against any insurance company for the terms of the policy, including PIP (Personal Injury Protection) and the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician facility named above, you are hereby tendered demand to pay in full the bill or services rendered by the physician/facility named above within 30 days following your receipt of such bill for services to extent such bills are payable under the terms of the policy. This demand specifically conforms to Article 21.55 of The Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to Houston Spine Wellness, PC, and to send any and all checks to 2811 Airline Drive, Unit 7 Houston, Texas 77009.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to cut a separate draft to pay in full all services rendered, payable directly to Houston Spine Wellness, PC and to send any and all checks to 2811 Airline Drive, Unit 7 Houston, Texas 77009.

STATUTE OF LIMITATION: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court costs incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/clinic named above to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM claim on my behalf. I also instruct my insurance carrier to provide upon the request of the provider/clinic named above, copies of my signed and dated rejections in writing as they apply to my lack of PIP or UM/UIM coverage. If my carrier is unable to provide said rejections in a timely manner, I acknowledge that I am entitled to a minimum level of coverage, as per section 1952.152 of the Texas Insurance Code, and further instruct my carrier to pay up to available limits directly to physician/clinic named above, and to send any and all checks or financial instruments to 2811 Airline Drive, Unit 7 Houston, Texas 77009.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommend to me by caring doctor at this clinic, he has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor I will notify this facility immediately. I understand that failure to do so may jeopardize my case.

Signature of patient and/or responsible parties:

_____ Date: _____

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HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization

I authorize Houston Spine Wellness, P.C. (Dr. Bijan Eshkevari) to use and disclose the protected health information described below to _____.
Facility Requesting Information

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the exception of the following information:

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□ Mental health records

□ Communicable diseases (including HIV and AIDS)

□ Alcohol/drug abuse treatment

□ Other (please specify): _____

1. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

2. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

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Date

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Missed Appointment Policy

Here at Houston Spine Wellness, P.C. we encourage you (patient) to keep appointments designated by the doctor. We understand unforeseen events can occur, so we request that you (patient) call at least 24 hours in advance to cancel or reschedule appointments, allowing appointment availability for other patients requesting to see the doctor. A failed appointment or failure to contact our office at least 24 hours in advance will result in a $25 failed appointment fee.

I _____ have read and understand the missed appointment policy.

Patient Signature Date