ACCIDENT
CONFIDENTIAL PATIENT INFORMATION

MEMPHIS SPINE AND REHAB
8132 CORDOVA RD, STE 102
CORDOVA, TN 38016
901-751-0939

DATE:_____

PERSONAL INJURY PATIENT CASE HISTORY

NAME: _____HOME PHONE:_____ Cell Phone: _____

Social Security Number_____ Sex □M □F Drivers License #:_____

Age:_____ Date of Birth:_____ Marital Status M S W D How many children:_____

Address_____City_____ST_____Zip_____
Occupation_____ Employer_____

Spouse's Name_____Spouse's Phone: _____
Name of nearest relative_____Home Phone_____Cell Phone_____
Other Doctors Seen For this Condition:_____

ACCIDENT DETAILS

Insurance Companies Involved:
My Company:_____
Company of Person Responsible for Injuries:_____
Date of Accident_____Hour_____ □AM □PM Location_____
How did accident occur if not in automobile? _____
If Auto Collision, Were You Stuck From ..... Behind □ **Right Side** □ **Left Side** □ **Front** □
Have you had similar accident before? _____When? _____
What Operations have you had?_____When? _____
Unusual Diseases? _____When? _____
Serious Diseases? _____When? _____
Are you pregnant or possibility of pregnancy? □ Yes □No
Do you have an Attorney that has advised you in this case? □ Yes □No
Have you lost any Days work? □ Yes □No Dates:_____
Have you been treated for any health condition by a physician in the past year? □ Yes □No
Describe: _____

CHECK SYMPTOMS YOU HAVE NOTICE SINCE ACCIDENT

□Headache	□Neck Pain	□Neck Stiffness	□Sleeping Problems
□Back Pain	□Chest Pain	□Pins & Needles in extremities	□Dizziness
□Numbness in extremities	□Short of Breath	□Nervousness	□Lights bother Eyes
□Loss of Memory	□Ears Ring	□Fatigue	□Loss of Balance
□Depression	□Fainting	□Cold Feet	□Tension
□Diarrhea	□Constipation	□Stomach Upset	□Irritability
□Fever			

Symptoms Other Than Above: _____
What Medications or Drugs Are you taking:_____

I consent to the treatment necessary for proper care. I consent to the use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. My consent of disclosure of records shall be effective until I revoke it in writing.

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and me. Furthermore, I understand that **Memphis Spine and Rehab Center** will prepare any necessary reports and forms to assist me in making collection from the insurance company and that payment shall be paid directly to **Memphis Spine and Rehab Center** which will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am financially responsible for payment. I also understand that if I suspend or terminate my care & treatment, any fees for professional services rendered me will be immediately due and payable.
By signing this statement, I agree to be responsible for payment of services not paid. "In the event of default, I agree to pay all collection cost 33.3%, including attorney fees and or collection company cost."
I attest to the accuracy of the information on this page.

Patient's Signature: _____Date _____
Guardian Signature Authorizing Care: _____ Date _____
Information Taken By: _____ Date _____

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INSURANCE INFORMATION FOR ACCIDENT CASE

Date of Accident: _____ Were you the driver or passenger? _____

_____

PATIENT CAR INSURANCE INFORMATION

Patient's Name _____ Age _____ Birthday _____

Patient's Auto Insurance Company Name _____

Auto Insurance Company's Address & Phone: _____

_____

Name of Insured _____ Policy: _____

Patient Driver Owner of Vehicle

Adjuster's Name _____ Phone: _____

Claim# _____ Fax: _____

Med Coverage: _____

Verified by: _____ Date Verified: _____ Send records by: Fax Mail Email

INSURANCE COMPANY OF THE OTHER PARTY IN THE ACCIDENT

Insurance Company Name _____

Address & Phone Number _____

_____

Name of Insured _____ Policy: _____

Insured Address & Phone _____

_____

Adjuster's Name _____ Phone: _____

Claim# _____ Fax: _____

Med Coverage: _____

Verified by: _____ Date Verified: _____ Send records by: Fax Mail Email

ATTORNEY INFORMATION

Attorney's Name _____

Phone: _____ Fax: _____

Address _____

_____

I understand that I must provide all the above information to MEMPHIS SPINE AND REHAB CENTER due to the fact that services are to be paid for as rendered. Therefore, all insurance available will be billed during my treatment.

Patient's Signature: _____ Date: _____

MEMPHIS SPINE AND REHAB CENTER
8132 CORDOVA RD, STE 102
CORDOVA, TN 38018
901-751-0936

PERSONAL INJURY QUESTIONNAIRE

PATIENT: _____

ACCIDENT DATE: _____ TIME: _____

PLEASE DESCRIBE THE ACCIDENT IN YOUR OWN WORDS: _____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR ACCIDENT AND INJURY:

What was your position in the car? ☐ Driver ☐ Passenger
If passenger, were you in? ☐ Front Seat ☐ Right Rear Seat ☐ Left Rear Seat ☐ Other
Were you wearing a seat belt? ☐ Yes ☐ No
If so, what type? ☐ Lap ☐ Shoulder
Did your seat have a head restraint (headrest)? ☐ Yes ☐ No
If so, what was the headrest position? ☐ Low ☐ Mid Position ☐ High
Did your vehicle strike the other vehicle? ☐ Yes ☐ No
Was your vehicle struck by another vehicle? ☐ Yes ☐ No
Was the impact from the: ☐ Front ☐ Rear ☐ Left Side ☐ Right Side
What was the approximate speed at the time of impact? Your vehicle: _____MPHOther Vehicle: _____MPH
What were the road conditions? ☐ Dry ☐ Wet ☐ Icy
At the time of impact were you looking: ☐ Straight ☐ Right ☐ Left ☐ Down ☐ Up
Were both hands on the steering wheel? ☐ Yes ☐ No
If NO, which hand was on the steering wheel? ☐ Right ☐ Left
Was your foot on the brake? ☐ Yes ☐ No
If so, which foot? ☐ Right ☐ Left
Were you braced at the time of impact? ☐ Yes ☐ No
Did you strike anything at the time of impact? ☐ Yes ☐ No
If so, please specify: ☐ Seatbelt Restraint ☐ Dashboard ☐ Windshield ☐ Side Door ☐ Side Window ☐ other: _____
Please state part of body you struck: ☐ Chest ☐ Head ☐ Chin ☐ Face ☐ Right/Left Knee ☐ Right/Left Shoulder ☐ other: _____
Immediately after the accident were you: ☐ Conscious ☐ Dazed ☐ Unconscious

I consent to treatment necessary for proper care. I consent to the use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. My consent to disclosure of medical records shall be effective until I revoke it in writing.

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself. Furthermore, I understand that Memphis Spine and Rehab will prepare any necessary reports and forms to assist me in making collection from the insurance company and those payments shall be paid directly to Memphis Spine and Rehab, which will be credited to my account upon receipt. However, I clearly understand and agree that all se4rvices rendered me are charged directly to me and that I am financially responsible for payment. I also understand that if I suspend or terminate my care and treatment, an fees for professional services rendered me will be immediately due and payable. By signing this statement, I agree to be responsible for payment of services not paid. "In the event of default, I agree to pay all collections costs 33.3%, including attorney fees and or collection company costs 33.3%."

Patient's Signature: _____ Date: _____

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HIPAA / PRIVACY PRACTICES

SECTION A: THE PATIENT INFORMATION

NAME:_____

ADDRESS:_____

TELEPHONE:_____ **EMAIL:**_____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice

I, _____, acknowledge that I have an understanding of the Notice of Privacy Practices from Memphis Spine and Rehab Center.

Signature:_____ Date:_____

SECTION C: HIPAA

Who may we speak with regarding your medical care/appointments?

_____ **(Please Print)**

Relationship: _____

I am authorizing the staff of Memphis Spine and Rehab to speak to the above persons on my behalf. The person listed above is able to gain information of my care or adjust appointments on my behalf. If patient is a minor (Under the age 17 is considered a minor)

If you have a power of attorney for the patient please provide us with a copy of the power of attorney it must state it is for healthcare. If you are a representative for the patient due to translation please note that on the line identified as relationship listed above. If patient is unable to sign this form due to a medical condition please note below.

Patient Signature: _____ **Date:**_____

POA/ Patient Representative: _____

Note:_____

_____