Reynoldsburg Chiropractic Center

7323 East Main Street • Reynoldsburg, Ohio 43068
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AUTO/PERSONAL ACCIDENT QUESTIONAIRE

Date of Accident: _____ Time _____ am pm

Location: _____

How did accident occur? _____

Describe the Circumstances _____

_____

Vehicle you were in: Year: _____ Make: _____ Model: _____

Other vehicle: Year: _____ Make: _____ Model: _____

Did you report accident to employer? ____yes ____no

If auto accident were you: ____driver ____passenger ____pedestrain

Were you struck from: ____behind ____front ____L side ____R side ____parked

Were you wearing a seat belt? ____yes ____no if yes, ____lap seat belt ____shoulder-lap seat belt

Was you car stopped at time of impact? ____yes ____no if no, approximate speed _____m.p.h.

Was the other vehicle moving at time of impact? ____yes ____no if yes, approximate speed _____mph

Did your vehicle strike another vehicle? ____yes ____no

Did another car strike you? ____yes ____no

Traffic citations were issued to: ____you ____driver of other car ____driver of your car

What is the estimated cost of damage to the vehicle you were in? $_____

Did you go to the emergency room as a result of this accident? ____yes ____no

List the extent of injuries as you know them: _____

_____

Check symptoms you have noticed since the accident:

____Headache	____Nervousness	____Loss of memory
____Head seems too heavy	____Pins and needles in arms	____Loss of smell
____Neck pain stiffness	____Pins and needles in legs	____Loss of taste
____Upper back pain/stiffness	____Numbness in fingers	____Diarrhea
____Mid back pain/stiffness	____Numbness in toes	____Feet cold
____Low back pain/stiffness	____Loss of balance	____Hands cold
____Shoulder pain/stiffness	____Ringing/buzzing in ears	____Stomach upset
____General stiffness	____Dizziness	____Constipation
____Fatigue	____Shortness of breath	____Cold sweats
____Irritability	____Chest pain	____Fever
____Depression	____Light bothers eyes	____Fainting
____Tension	____Sleeping problems	

Symptoms other than above: _____

Have you missed any days of work? ____yes ____no if yes, how many? _____

Insurance companies involved:

My insurance company _____

Company of person responsible for injuries _____

Do you have an attorney that has advised you in this claim? ____yes ____no

Attorney information: Name_____ Phone_____

Address _____

Have you considered using an attorney to handle the settlement of your claim? ____yes ____no

REYNOLDSBURG CHIROPRACTIC CENTER
7323 E. MAIN STREET
REYNOLDSBURG, OH 43068
614-861-6222

FINANCIAL POLICY

Welcome to our office. Thank you for choosing us for your chiropractic care. We are committed to providing you with the best possible care expecting the most successful results. Your clear understanding of our financial policy is important to our professional relationship. Please understand that payment of your bill is considered part of your overall treatment. In order to keep your out of pocket costs to an absolute minimum, we have adopted the following policies.

FEES AND PAYMENTS

Fees are standardized and are based on medical necessity. Payment of co-pays and any outstanding balance is required at the time of service. We accept cash, personal checks, debit or credit cards. We also offer a Credit/Debit Card Guarantee program allowing you to put your card information on file with us to be accessed weekly if balances are present. This is especially helpful for those policies with deductibles and/or co-insurances as balances are not always available at the time you are in the office. We can run your card as your balances become available.

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. In order for us to file a claim, you must present a current copy of your insurances card(s) and communicate any changes as they happen. Most insurance companies have filing deadlines and if we receive your new information too late, you may be responsible for those charges.

Most insurance policies specify that some of the cost of the patient's care is the patient's responsibility. This can be accomplished through any combination of copays, co-insurances or deductibles. Copays are due at the time of service as you check out. Coinsurance and deductibles are determined by your insurance company and reported to us on your explanation of benefits (EOB's). Once we receive your EOB, we will add the appropriate charge to your account. You will be informed of this balance as you check out, or be sent a statement (due upon receipt) if you do not have an appointment at that time. This is also where your Credit/Debit Card Guarantee on file would be helpful.

INSURANCE PLANS

Your insurance coverage is a contract between you, your employer and the insurance company...we are not a part of that contract. It is important for you to understand that our relationship is with you and not with your insurance company.

Not all services that we deem necessary for your treatment are covered in all plans, so it is very important that you understand the provisions of your individual policy. As a courtesy to you, we will call your insurance company for your coverage and benefits and explain them to you as they were told to us. You also may call your insurance company any time you have questions about your coverage and

benefits. Keep in mind, some insurance companies select certain services they will not cover, so we cannot guarantee payment of all claims by your insurance company. We do offer self-pay fees for uncovered services. Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation.

Bureau of Workers' Compensation accounts are considered to be self-pay or health insurance until we are aware that an approved C-9 has been received from BWC recognizing that your injury is related to a valid Workers' Compensation claim.

MAKING AND KEEPING APPOINTMENTS

If you need to cancel or reschedule your appointment, please call us as soon as possible. We are very flexible and accommodating and will work with your schedule as much as we can while also taking into consideration the doctor's schedule. Your treatment plan is designed to give you the fastest, most effective recovery based on our experience with similar conditions. Your adherence to this plan makes it most effective. Everyone's body responds differently, so if your recovery is faster or slower than the prescribed plan, Dr. Kohl will revise your treatment plan. Excessive cancellations or no shows may result in a charge being added to your account and you may be dismissed from care.

NON-PAYMENT OF OUTSTANDING BALANCES

Accounts that are not paid in a reasonable amount of time may be sent to an external collection agency and reported to the credit bureaus. In addition to your outstanding balance, you may also be responsible for any fees or charges incurred from the external collection agency while attempting to collect your balance.

ADMINISTRATIVE FEES

Forms Charge – If your employer requires Family Medical Leave Act (FMLA) or Disability paperwork to be completed by the doctor, the turnaround time may be up to five business days and there is a $10-$25 fee for this service, payable in advance.

Medical Records Charge – If you would like a copy of your medical records sent to yourself or another physician, these copies are billed on a per page basis, payable in advance. If Dr. Kohl recommends you see another doctor and they request your medical records, there is no fee.

Returned Check Charge -- Non-Sufficient Funds (NSF) checks are subject to a $30 fee.

I HAVE READ AND UNDERSTAND THESE POLICIES

SIGNATURE _____. ***DATE*** _____.

PRINT NAME _____.

WITNESS _____.