Please initial each box as each item is completed. All items must be completed before you return your PI Questionnaire.

☐	Call the number on the back of *your auto insurance card* and let them know that you have been injured and want to open a Med Pay claim. **Do not call your agent**—they cannot do this for you. • This claim number may be different than the claim number for the auto accident, or it may be the same. You must call to open the medical claim either way. • Please note that *your* Med Pay coverage is primary regardless of who was at-fault in your accident. Your insurance company may tell you that the at-fault party's insurance is responsible, but this is NOT correct. *You pay each month for Med Pay coverage as part of your premium, and it is in your best interest to use it in order to keep your costs for treatment to a minimum.* • Once your Med Pay coverage has been depleted, your claims will be forwarded to 3rd Party (if applicable) at the end of your treatment. • Enter all claim information in Section 2, item 1 of the Personal Injury Questionnaire.
☐	If you have been told by your auto insurance company that you do not have Med Pay on your policy, you will need to ask for a copy of the "opt-out letter." This is a document you will have signed rejecting Med Pay coverage. • If your auto insurance company cannot provide a signed document rejecting Med Pay coverage, they are legally required to pay your claims. • Provide us with the copy of the opt-out letter when you return your PI Questionnaire.
☐	If you were not at fault in the accident, please contact the other party's auto insurance company and let them know that you were injured and ask for a Medical Claim number. *Please note that we need this information whether you have Med Pay coverage or not—once Med Pay is depleted, we will send your bills to 3rd Party at the end of your treatment.* • When you open your Medical Claim with 3rd Party, let them know you are being treated here and provide them with our contact information. • This claim number may be different than the claim number for the auto accident, or it may be the same. You must call to open the medical claim either way. • Enter all claim information in Section 2, item 2 of the Personal Injury Questionnaire.
☐	If you have Medical Insurance, please enter this information in Section 1, item 1 of the Personal Injury Questionnaire.

☐	If you have hired an attorney, please enter their information in Section 1, item 2 of the Personal Injury Questionnaire. • Please inform your attorney that you are being treated here and provide them with our contact information.
☐	Fill out **all sections** of the Personal Injury Questionnaire, and be as thorough as possible.
☐	Make sure you initial **all statements** on the final page of the Personal Injury Questionnaire. • If you do not initial all statements on this page, we will be unable to bill any insurance company for your treatment, and you will be responsible for your full balance.

Important things to keep in mind:

- Your auto insurance company or the other party's insurance company may contact you regarding your injuries and treatment.
    - If this happens, the only thing you need to tell them is that you are **still actively treating at this time**.
    - When in doubt, provide them with our phone number and tell them they are welcome to speak with your provider if they have further questions.
- The 3rd Party insurance company may send you a check in an attempt to settle your claim before you are finished treating.
    - Please be aware that acceptance of this check would constitute an agreement of settlement. If you cash the check, you are not entitled to any further payment! If you aren't sure, always contact us.
- The completed Personal Injury Questionnaire must be returned to our office within 3 days of your initial date of service for this accident.
    - If we do not receive the Questionnaire within this time frame, you will be required to pay your full balance, and pay for your treatment at the time of service going forward.

Name: _____ File: _____

Personal Injury Questionnaire

(PLEASE PRINT CLEARLY) Date: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Social Security #: _____- _____-_____ Birth Date: _____/_____/_____ Age:_____

☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced/Separated ☐ Widowed

Accident/Injury Information:

Please indicate the type of accident in which you were involved:

☐ auto ☐ work ☐ fall ☐ other: _____

Date of Accident: _____ Time: _____ ☐ am/ ☐ pm Location: _____

In your own words, please describe the accident/injury: _____

_____

_____

_____

SECTION 1 – MEDICAL INSURANCE AND ATTORNEY INFORMATION

1. MEDICAL INSURANCE INFORMATION Check here if no insurance ☐

Insurance Company: _____ ID #: _____

Subscriber's Name: _____ Date of Birth: _____

Name: _____ File: _____

2. ATTORNEY INFORMATION Check here if no attorney retained ☐

Law Firm Name: _____ Phone: _____

Attorney's Name: _____

SECTION 2 – AUTO INSURANCE INFORMATION

1. YOUR CAR INSURANCE INFORMATION

IMPORTANT: This section must be completed in full whether you were at fault or not—If we are unable to obtain this information, you will be financially responsible for your treatment.

Were you in your car at the time of the accident? ☐ Yes ☐ No – Driver's name: _____

Policy Holder Name: _____ Insurance Company: _____

Medical Claims Address: _____

Policy #: _____ Medical Claim #: _____

Medical Claims Adjuster Name: _____

Medical Claims Adjuster Phone #: _____

Make/Model of Car: _____

Has this insurance company been notified? ☐ Yes ☐ No Is there "Med-Pay" on this policy? ☐ Yes ☐ No

Have you spoken to someone at your insurance company regarding this claim? ☐ Yes ☐ No

Were you at-fault in this accident? ☐ Yes ☐ No

2. CAR INSURANCE OF THE OTHER PARTY THAT WAS INVOLVED IN THE ACCIDENT

Policy Holder Name: _____ Insurance Company: _____

Medical Claims Address: _____

Policy #: _____ Medical Claim #: _____

Medical Claims Adjuster Name: _____

Medical Claims Adjuster Phone #: _____

Make/Model of Car: _____

Has this insurance company been notified? ☐ Yes ☐ No Driver's Name _____

Did you open a medical claim with this insurance company? ☐ Yes ☐ No

Name: _____ File: _____

SECTION 3 – NATURE OF ACCIDENT

Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat

Was anyone issued a citation for this accident? ☐ Yes ☐ No If yes, who? _____

If you were not the driver, driver's name: _____

Were you wearing seatbelts/helmets? _____

Did an airbag deploy? If yes, which one(s)? _____

Approximate speed of your car: _____ mph Approximate speed of other car: _____mph

The accident was: ☐ Single car crash ☐ Two vehicle crash ☐ > 2 vehicles ☐ Head-on crash

☐ Side crash ☐ Rollover ☐ Rear-end crash ☐ Hit guard rail/tree ☐ Ran off road

SECTION 4 – INJURY INFORMATION

Where were you taken after the accident? _____

Have you been treated by another doctor since the accident? ☐ Yes ☐ No If yes, please list who you have seen and what treatment was rendered? _____

_____

_____

Since the accident, are your symptoms: ☐ Improving ☐ Worsening ☐ Remaining the same

Check symptoms that you have noticed since the accident:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiffness	☐ Dizziness	☐ Fatigue	☐ Loss of balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles – Arms	☐ Light Bothers Eyes	☐ Loss of Smell	☐ Cold sweats
☐ Nervousness	☐ Pins & Needles – Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ringing in Ears	☐ Diarrhea	☐ Other (list below)

Please complete the following page.

Name: _____ File: _____

Read each of the following statements and initial.

_____ I understand that I am directly and fully responsible for all medical bills for services rendered to me.

_____ I understand that this office requires Med Pay benefits to be used first if such benefits are available.

_____ I understand that if it is necessary for the treating provider to wait for payment, a lien may be filed with the county and/or my attorney.

_____ I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize payment to be made directly to the treating provider or clinic under which the services are billed.

_____ For medical claims, I direct any funds due the provider to be paid directly to the treating provider or clinic. Any funds included in Third Party settlement which are due to the provider are to be paid directly to the provider on my behalf.

_____ I understand that payment for Third Party claims may be paid directly to me. I further understand it is then my obligation to forward payment to the treating provider or clinic.

_____ _____

Patient Name Relationship to Patient

_____ _____

Signature of patient, or responsible party for minor Date