



M5 Chiropractic Professional, LLC
10789 Bradford Road, Suite 110
Littleton, CO 80127

To my Personal Injury Patients,

When you speak to your insurance company, the 3rd party insurance company (at-fault party), or your attorney, please let them know that you are being treated under **M5 Chiropractic Professional, DBA Crossroads Family Chiropractic.**

Thank you,

Mitchell Moret, DC

Patient Signature

Date

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

<input data-bbox="126 495 232 600" type="checkbox"/>	<p>Call the number on the back of <i>your auto insurance card</i> 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.</p> <ul style="list-style-type: none"> • 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 <i>your Med Pay coverage</i> 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. <i>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.</i> • 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.
<input data-bbox="126 972 232 1077" type="checkbox"/>	<p>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.</p> <ul style="list-style-type: none"> • 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.
<input data-bbox="126 1377 232 1482" type="checkbox"/>	<p>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. <i>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.</i></p> <ul style="list-style-type: none"> • 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.
<input data-bbox="126 1728 232 1833" type="checkbox"/>	<p>If you have Medical Insurance, please enter this information in Section 1, item 1 of the Personal Injury Questionnaire.</p>

<input type="checkbox"/>	<p>If you have hired an attorney, please enter their information in Section 1, item 2 of the Personal Injury Questionnaire.</p> <ul style="list-style-type: none">• Please inform your attorney that you are being treated here and provide them with our contact information.
<input type="checkbox"/>	<p>Fill out all sections of the Personal Injury Questionnaire, and be as thorough as possible.</p>
<input type="checkbox"/>	<p>Make sure you initial all statements on the final page of the Personal Injury Questionnaire.</p> <ul style="list-style-type: none">• 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.

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