NonSurgical Medical Group, Inc.

PERSONAL INJURY QUESTIONNAIRE

Name ____
Last First MI

Email Address ____

Mailing Address ____

City _________________________________State______ Zip______________

Phone: (H)________________ (W)________________ (Mobile) ________________

Age: _____ Date of Birth_________________________ Sex : ☐ Male ☐ Female

Your Auto Insurance Carrier________________________ Policy#_______________
Please provide a copy of your Declaration page of your Auto Policy

Other Driver's Name (Responsible Party) ______________________ Phone_________

Address ____

City _________________________________State______ Zip______________

Policy Holder's Name__________________________ Policy#__________________

Policy Holder's Insurance Carrier_______________________ Claim#_____________

Adjuster or Agent ____________________________Phone______________________

ATTORNEY

Name ______________________________Firm Name_________________________

Address____

City ______________________________________State _____Zip______________

Phone ______________________________ Fax______________________________

ACCIDENT AUTO DETAILS:

1. Date of Accident ____________Time__________ Weather__________________

   Your Vehicle Make/Model/Year _______________________________________

   Other Vehicle(s)Make/Model/Year_____________________________________

   You were the: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

3. Number of People in Vehicle_____ Were you wearing seatbelts ? ( ) Yes ( ) No

4. What direction were you headed? ( ) North ( ) South ( ) East ( ) West

   On what street ________________________ City _______________________

   Nearest Cross-Street ____

5. What direction was the other vehicle headed?

   ( ) North ( ) South ( ) East ( ) West On what street _________________

6. Were you struck from: ( ) Back ( ) Front ( ) Left side ( ) Right side

7. Approximate speed of your car ______ mph Other car _____mph

FOR ALL ACCIDENTS/PERSONAL INJURIES:

8. Were you knocked unconscious? ( ) Yes ( ) No If yes, how long?

9. In your own words, please describe the accident:

   ____

   ____

   ____

10. Did you have any physical complaints BEFORE the accident? ( ) Yes ( ) No

    If yes, please describe in detail:

    ____

    ____

    ____

11. Please describe how you felt:

a. DURING the accident: ____

b. IMMEDIATELY AFTER the accident:_______________________________

c. LATER THAT DAY: ____

d. THE NEXT DAY:____

12. What are your PRESENT complaints and symptoms?

____

____

____

13. Do you have any congential (from birth) factors which relate to the problem?

( ) Yes ( ) No If yes, please describe:

____

14. Do you have any previous illness which relates to this case? ( ) Yes ( ) No

If yes, please describe:

____

15. Have you ever been involved in an accident before? ( ) Yes ( ) No

If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received:

____

____

____

16. Where were you taken after the accident? _______________________________

____

How were you transported? ____

17. Have you been examined and/or treated by another doctor since the accident?

( ) Yes ( ) No

If yes, please list hospital and/or doctor(s) name and address:

____

____

____

18. What type of treatment did you receive?

____

____

19. Since this injury occurred, are your symptoms:

( ) Improving ( ) Getting Worse ( ) Same

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

If yes, please complete this question:

a. Last day worked: ____

b. Type of employment: ____

21. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No

If yes, please describe, in detail:

____

22. Other pertinent information:

____

____

____

_____________ ____

Date Patient's Signature

IRREVOCABLE ASSIGNMENT, LIEN AND AUTHORIZATION
INSURANCE BENEFITS AND ATTORNEY

TO WHOM IT MAY CONCERN:

I hereby authorize and direct you, my insurance carrier and/or attorney to pay directly to NonSurgical Medical Group, Inc. such sums as may be due and owing this office for services rendered to me, both by reason of accident or illness and by reason of any other bills that are due this office. Please withhold such sums from any disability benefits, med-pay benefits, no-fault benefits, health and accident, Workers' Compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect the lien for medical services provided by NonSurgical Medical Group, Inc. I hereby further give lien to said office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated for by NonSurgical Medical Group, Inc. This document is to act as an assignment of my rights and benefits to the extent of services provided by NonSurgical Medical Group, Inc.

I understand that I remain personally responsible for the total amounts due to the office for services rendered. I further understand and agree that this Assignment, Lien, and Authorization does not constitute an agreement for a delay in payments, and they may demand payments from me immediately upon rendering services at their option.

I authorize the office to release any information pertinent to my case to any insurance carrier, adjuster or attorney to facilitate collection under this Assignment, Lien, and Authorization.

I further understand and agree that if NonSurgical Medical Group, Inc. must take action to collect an outstanding balance on this account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to all court costs and all attorney fees.

______________________________ ________________
Patient Signature Date

I authorize my Attorney ____________________________ to sign this lien to pay the outstanding balance at settlement under NC General Statute § 44-50.

______________________________ ________________
Patient Signature Date

Please sign this Assignment, Lien, and Authorization and return to NonSurgical Medical Group, Inc.

______________________________(SEAL) ________________
Attorney Date

NonSurgical Medical Group, Inc.

Personal Injury Financial Policy

1. If an attorney represents you:

   You must provide us with their name, address, phone, and fax numbers prior to receiving services.

   Your attorney must sign and fax our lien to us within 24 hours of your initial visit to our office.

2. If an attorney does not represent you:

   You must sign a lien assigning payments for our services directly to us from all applicable insurance carrier(s) or individuals prior to receiving services.

   Please provide us with information/declaration pages/membership cards for the following three insurances:

   A. Personal Health Insurance
   B. Your Auto Insurance
   C. Third Party Auto Insurance (Person who hit you)

*__Regardless of whether you have an attorney, if you do not have insurance, you will be considered a cash patient and expected to pay at the time services are rendered.__

I have read and agree to the above terms.

_______________________________________ ________________________
Patient Signature Date

Personal Health Ins ☐
Patient's Auto Ins ☐
Third Party Auto Ins ☐

Direct Pay to the Provider Agreement

Patient Name:__________________________ Date:__________________________

D.O.B:________________________________ D.O.I._________________________

File Number:___________________________

I ______________________________________ authorize **direct payment** to NONSURGICAL MEDICAL GROUP, INC. for services received as a result of personal injury. All bills submitted by NONSURGICAL MEDICAL GROUP, INC must be paid by insurance carriers, attorneys, and/or individuals. A **separate check** must be issued soley to and mailed to:

NONSURGICAL MEDICAL GROUP, INC.
3801 SOUTH HARBOR BLVD. SUITE B
SANTA ANA, CA 92704
(714) 751-5555

The insurance carrier(s), attorney, and/or individual will pay the **full amount** billed by NONSURGIAL MEDICAL GROUP, INC. from the patient's settlement as agreed upon by the provider and the patient.

____ ____________________

Patient Signature Date

Check Endorsement Agreement

Patient Name:_________________________ Date:_________________________

D.O.B:______________________________ D.O.I.:________________________

File Number:_________________________

I, _________________________________, agree to **endorse and submit all checks** received from insurance carriers, attorneys, and/or individuals to NONSURGICAL MEDICAL GROUP, INC. for services received as a result of personal injury. All checks must be submitted and endorsed to NONSURGICAL MEDICAL GROUP, INC. located at:

NONSURGICAL MEDICAL GROUP, INC.
3801 SOUTH HARBOR BLVD. SUITE B
SANTA ANA, CA 92704
(714) 751-5555

If the patient fails to deliver the check to NonSurgical Medical Group, Inc. within two (2) weeks from the issue date, the patient will nullify the payment arrangement with NonSurgical Medical Group, Inc. and the full amount will be due immediately.

____ ____________________

Patient Signature Date