Regional Medical Group

Accident Questionnaire / Personal Injury

☐ Dr. Eric Steenlage ☐ Dr. Srihari Malempati
☐ Dr. Angela Ashley ☐ Dr. Sadik Haba
☐ Dr. Jay Bender ☐ Dr. James Rogan

PATIENT INFORMATION

First Name/Nombre:	Middle Initial	Last /Apellido:	Patient Account Number:
Street Address/Direccion:	City/Ciudad:	State/Estado:	Zip/Codigo Postal:
Home Phone/# Casa:	Work Phone/Trabajo:	Cell Phone/# Celular:	
Sex: ☐ Female ☐ Male	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other	Date of Birth/Fecha de Nacimiento:	Age/Edad:
Social Security Number/Seguro Social:	Referred by: (Doctor)/Referido Medico:	(Attorney)/Abogado:	Spouse Name/Espso/a:
IN CASE OF EMERGENCY - Contact:		Relationship:	
Home Phone:		Work Phone:	

HEALTH INSURANCE INFORMATION

Primary Insurance Company Name:		Telephone #:	
Insurance Address:	City:	State:	Zip:
Policy Holder Name:	Identification #:		
Policy Holder Birth Date:	Group#:	Additional Info:	

AUTOMOBILE ACCIDENT INFORMATION

Date of Accident/Fecha de Accidente:	Med Pay? ☐ Yes ☐ No	If yes, how much? $	
Insurance Company:	Address:	City/State:	
Adjuster Claim Rep:	Claim #	Phone #:	

WORKERS' COMPENSATION INFORMATION

Date of Accident:	Employed By:	Phone #:
Insurance Company:	Address:	City/State:
Adjuster	Claim #	Phone #:
Claim Rep:		

OTHER ACCIDENT / INCIDENT INFORMATION

Other Accident/Incident Type (Describe Briefly):		
Insurance Company:	Address:	City/State:
Adjuster:	Claim #	Phone #:

ATTORNEY INFORMATION

Firm Name/Nombre de Firma:	Attorney Name/Abogado:	Phone #:
Address:	City/State:	Zip:

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hearby authorize payment of surgical and/or medical benefits to be paid directly to the physician, if any, otherwise payable to me for his/her services as described realizing that I am responsible to pay non-covered services. I further authorize the physician to release any information required in the course of my treatment necessary to process insurance claims.

Signature/Firma _____ Date/Fecha _____

Office Use Only (D/A) _____ (DX) _____

Regional Medical Group

Date_____

PATIENT MEDICAL INFORMATION

Patient Name_____Patient Account Number_____

List all medications that you were taking before the accident.

_____

Are you allergic to any medications? ☐ Yes ☐ No

If yes, which medication(s)?_____

Date of Last Medical Exam: _____ with whom? _____

LIST OF MAJOR SURGERIES

_____ Date: _____

_____ Date: _____

Have you had any major falls or accidents (automobile) in the past 3 years? Please describe below:

_____

SOCIAL AND OCCUPATIONAL HISTORY

Employed by:_____ ☐ Unemployed ☐ Housewife ☐ Student

Type of work:_____

# of children and ages:_____

(1.) Do you smoke cigarettes/tobacco? ☐ Yes ☐ No

(2.) Do you use any illegal substances? ☐ Yes ☐ No

(3.) Do you consume alcohol? ☐ Yes ☐ No ☐ Occasional

(4.) Are you HIV+/AIDS? ☐ Yes ☐ No

FEMALES ONLY

Date of last menstrual cycle _____

Is there a possibility you may be pregnant? ☐ Yes ☐ No

If yes, due date_____

Currently taking birth control pills? ☐ Yes ☐ No

Currently taking hormone replacement? ☐ Yes ☐ No

PREVIOUS ILLNESSES

Please advise which of the following conditions you have ever had.

ASTHMA:	SEIZURES:	NERVOUS CONDITIONS:
ARTHRITIS/BACK PAIN:	HEART PROBLEMS:	MENTAL ILLNESSES:
DEPRESSION:	DIABETES:	CANCER:
HIGH BLOOD PRESSURE:	STROKE:	HEADACHES:

FAMILY HISTORY

Has your mother or father had any of these above conditions?

Mother: _____

Father: _____

Regional Medical Group

Date_____

Patient Name_____ Patient Account Number_____

INJURY DATE AND LOCATION

Date of Injury: City/Town:

Intersection: Route/Highway:

YOUR POSITION IN AUTOMOBILE ACCIDENT

Were you: ☐ Driver ☐ Front seat passenger ☐ Backseat passenger ☐ Other_____

YOUR VEHICLE

Year, Make, Model: _____

Your estimated speed at the moment of the accident _____mph. ☐ Stopped ☐ Slowing ☐ Accelerating

Point of impact to your vehicle: ☐ Front ☐ Back ☐ Left ☐ Right ☐ Other:_____

Was the impact to your vehicle? ☐ Light ☐ Moderate ☐ Heavy Damage estimate $_____

AUTOMOBILE ACCIDENT DESCRIPTION

Please describe how the accident happened: _____

Did accident happen while you were on job? ☐ Yes ☐ No

Name of person driving the vehicle (if other than patient) _____

OTHER VEHICLE

Year, Make, Model: _____

Their estimated speed at the moment of the accident _____mph. ☐ Stopped ☐ Slowing ☐ Accelerating

Were there any other vehicles involved? ☐ Yes ☐ No

If yes, please describe: _____

SEAT BELTS AND AIRBAGS

Were you wearing a seatbelt? ☐ Yes ☐ No

Did your air bag deploy? ☐ Yes ☐ No Did your seat break or bend? ☐ Yes ☐ No

Regional Medical Group

Date_____

Patient Name_____ Patient Account Number_____

AT THE TIME OF IMPACT

Which way was your body pointed at the time of impact? ☐ Straight ☐ Right ☐ Left

Which way was your head pointed at the time of impact? ☐ Straight ☐ Right ☐ Left

Were you leaning forward at the time of impact? ☐ Yes ☐ No

Did you brace before impact or were you relaxed? ☐ Relaxed ☐ Braced - **Against What?**_____

Did any body part of yours strike anything within the vehicle at the time of impact? ☐ Yes ☐ No

If "YES", specify what part of your body struck what: (i.e. head, chest, left shoulder, right knee, etc.)

☐ Steering Wheel _____ ☐ Windshield _____ ☐ Dashboard _____

☐ Left Side Door _____ ☐ Right Side Door_____ ☐ Roof _____

☐ Left Window _____ ☐ Right Window _____ ☐ Other _____

Immediately following the accident, how did you feel? (Circle all that apply)

Dizzy Dazed Weak Upset Disoriented Nervous Nauseous Other:_____

Did you lose consciousness? ☐ Yes ☐ No For how long? _____

Were you able to get out of the vehicle on your own? ☐ Yes ☐ No

TREATMENT AT THE SCENE OF THE ACCIDENT

Did an ambulance come to the scene of the accident? ☐ Yes ☐ No

If yes, did you receive treatment at the scene of the accident? ☐ Yes ☐ No

What kind of treatment? _____

TREATMENT AT THE HOSPITAL

Were you transported to the hospital? ☐ Yes ☐ No If yes, which hospital? _____

How did you get there? ☐ Ambulance ☐ Police ☐ Private Transportation

Were you admitted? ☐ Yes ☐ No If yes, how long? _____

What treatment was given at the hospital? (check all that apply)

☐ None
☐ Pain Medication
☐ Muscle Relaxants
☐ Cervical/Neck Collar
☐ Instructed Regarding Concussion
☐ Instructed to call an Orthopedist/Neurologist
☐ CAT Scan/MRI
☐ X-rays
☐ Stitches
☐ Bandaged
☐ Physical Therapy
☐ Instructed Regarding Sprains & Strains
☐ Instructed to call a Private Physician
☐ Other: _____

OTHER DOCTORS

Have you seen any other Doctors for your injuries prior to coming to our office? ☐ Yes ☐ No

If yes, who and what did they do for you? _____

_____

Regional Medical Group

Date_____

Patient Name_____ Patient Account Number_____

CHIEF COMPLAINTS

Please "X" any complaints that you have been experiencing since your accident. Do not fill in the area "For Doctor Use Only".

FOR DOCTOR USE ONLY

"X"	COMPLAINTS	LOCATION				ONSET	VAS	DESCRIPTION / REMARKS
	NECK PAIN	LF	RT	MID	BILAT			
	JAW PAIN	LF	RT	BILAT				
	UPPER BACK PAIN	LF	RT	MID	BILAT			
	MID BACK PAIN	LF	RT	MID	BILAT			
	SHOULDER PAIN	LF	RT	BILAT				
	ARM / WRIST PAIN	LF	RT	BILAT				
	HAND / FINGER PAIN	LF	RT	BILAT				
	LOW BACK PAIN	LF	RT	MID	BILAT			
	HIP PAIN	LF	RT	BILAT				
	LEG / KNEE PAIN	LF	RT	BILAT				
	ANKLE / FOOT / TOES	LF	RT	BILAT				
	NUMBNESS / TINGLING	LF	RT	BILAT	↑ ↓			
	RADIATING PAIN	LF	RT	BILAT	↑ ↓			
	HEADACHES	LF	RT	FRONT	OCC			Duration: Freq:

OTHER COMPLAINTS

Please "X" any complaints that you have been experiencing since your accident.

FOR DOCTOR USE ONLY

	Anxiety	**Doctors Notes**
	When I am traveling in a vehicle	
	When someone else is driving and I do not feel in control	
	When another vehicle is following too close to me	
	When I get near the scene of where the accident occurred	
	Other:	
	Difficulty Sleeping	
	Because of pain and discomfort	
	Nlightmares about the accident	
	Other:	
	Please indicate the number of hours you are able to sleep at night:	
	Depression	
	What do you feel is causing you to be depressed?	
	Memory Loss	
	Concentration	
	Other	

ASSIGNMENT OF PROCEEDS AND/OR LIEN FOR MEDICAL SERVICES

Attorney: _____ **Patient:** _____

_____ **Patient #** _____ **D/A** _____

_____ **SSN #** _____ **DOB** _____

FOR VALUE RECEIVED, I hereby assign unto Regional Medical Group and/or its Physicians, hereinafter referred to as RMG, to the extent of my bill for health care services and all claims which I may have against any other party who's NEGLIGENCE may have caused my injuries on the above captioned date or who may be legally responsible for my injuries and health care costs.

I further assign to RMG a irrevocable lien in the amount of my outstanding medical bill for health care services rendered for an accident which occurred on the above captioned date against the proceeds of any insurance policy, health care plan, or any claim which I may have against any other party whose negligence may have caused my injuries. I fully understand & agree not to rescind my directive to my attorney to honor this lien.

I hereby authorize payment be made directly to the Regional Medical Group or its Assignee. I hereby appoint RMG irrevocable, to ask, demand, sue for, collect, endorse, sign, and receive any such insurance or other benefits or claims against other parties for my injuries. Although RMG shall be granted such powers contained herein, RMG is not obligated or compelled to exercise such powers but may do so at RMG discretion. RMG is further empowered to provide any and all information and documents pertaining to my policies including a copy of such policy and any information or supporting documentation concerning or touching upon the handling, calculation, processing, or payment of any claim.

I fully understand & agree not to rescind my directive to my attorney to honor this lien. Failure of my Attorney to sign this document does not release him/her of the fiduciary responsibility of ensuring that my outstanding medical bill is paid unto RMG.

BY SIGNING YOUR NAME BELOW YOU CERTIFY THE ACCURACY OF YOUR MEDICAL AND/OR ACCIDENT HISTORY AND FURTHER CERTIFY THAT YOU PRESENTED TO REGIONAL MEDICAL GROUP AND ITS DOCTORS FOR EVALUATION AND/OR TREATMENT OF A HEALTH RELATED CONDITION OCCURING ON THE ABOVE DATE AND FOR NO OTHER PURPOSE.

BY SIGNING THIS DOCUMENT, PATIENT FULLY UNDERSTANDS ALL PROVISIONS SET FORTH IN THIS AGREEMENT. A PHOTOCOPY OR FAX COPY OF THIS AGREEMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

In the event that any provision of this agreement is determined to be invalid or unenforceable, all other provisions of this agreement shall remain enforceable.

IN WITNESS WHEREOF, the Agreement has been entered the day and year set forth below.

_____ _____

Patient/Guardian Signature Date

_____ _____

Witness Date

To be Completed by your Attorney:

The undersigned Attorney of Record for the above-named Patient, hereby agrees to observe all terms stated herein and agrees to withhold such sum payable to RMG from any settlement, judgment or verdict as may be necessary to adequately protect RMG. Attorney is expressly directed to hold in Attorney's Client Trust Account such sums from any payment, settlements, dispositions, proceeds and/or verdicts received on Patient's behalf as may be required to adequately protect and pay RMG for services rendered on Patients behalf by RMG. Attorney is further directed to pay from Attorney's Client Trust Account to RMG that amount which is due and owing to RMG for those medical services, examinations, treatments and reports which RMG has prepared on Patient's behalf. Attorney further agrees that in the event Patient secures other counsel in connection with any action instituted by Patient on account of the injuries for which Patient was treated, Attorney shall inform such new counsel of the Agreement, and secure new counsel's consent there to. Failure of Plaintiff Attorney to sign and return this document to RMG does not release him/her of the fiduciary responsibility of ensuring that the above Patient's outstanding medical bill for treatment rendered for injuries sustained on the above captioned date is paid unto RMG out of the proceeds of his/her case per your client's written request.

Attorney's Signature: _____ **Date:** _____

Attorney: Please sign and mail or fax to Regional Medical Group at the address/fax # below:

5335 Roswell Road, Atlanta, GA 30342 Telephone: 404-943-9996 Fax: 404-943-9975

Regional Medical Group

Authorizations and Releases / Financial Policy

Name: _____ **Patient #** _____

CONSENT FOR TREATMENT

_____ Initial

I, the undersigned, hereby authorize the Doctors of Regional Medical Group (RMG) and whomever they may designate as their assistant(s) to perform diagnostic tests, and to administer treatment as is necessary to me. I also certify that no guarantee or assurance has been made to the results that may be obtained.

CONSENT FOR TREATMENT OF MINOR

_____ Initial

I hereby authorize the Doctors of RMG, and whomever they may designate as their assistant(s), to perform diagnostic tests, and to administer treatment as he/she deems necessary to my child, (Child's name) _____ of which I am the legal guardian.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____ Initial

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify all insurance information given by me to this clinic is correct and complete.

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

_____ Initial

I hereby authorize my Insurance Company/Insurance Administrator to pay unto Regional Medical Group for any benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges out of the proceeds of my settlement and understanding that my attorney will be billed for said balance. I agree that this office be given power of attorney to endorse/sign my name on any and all draft for payment of my outstanding medical bill only.

ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE

_____ Initial

I, the undersigned patient am directing my Attorney, _____, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made soley for the doctor's additional protection and consideration of his/her awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payment as services are rendered.

PAYMENT POLICY

Health Insurance:

Proof of Insurance must be provided in order for us to file claims with your insurance company. Please understand that benefits through health insurance policies differ. Insurance companies pay according to your individual policy limits. Benefits are between you and your insurance company. You with your insurance company MUST handle any discrepancy regarding benefit coverage. Any portion of your bill that is not paid by your health insurance will be billed to your Attorney and will be paid at the time of your settlement.

Auto Insurance:

We cannot file against the adverse driver's insurance in an automobile accident. If Med Pay is available, we can will file against either your automobile insurance, or the owner of the vehicle you were a passenger in. If medical benefits are available there may be a maximum allowable amount of coverage which may not cover all charges in full. In that event you will be responsible for the remaining balance and your Attorney will be billed.

Worker's Compensation:

We will file with your employer's workers' compensation insurance company upon approval of each visit or procedure by the proper authority in the case. Should the case be controverted or denied for any reason we cannot file with the workers' compensation insurance on future claims and you will be responsible for the unpaid claims unless financial arrangements with your attorney have been made.

PATIENT REFUND POLICY

The Doctors of Regional Medical Group expect to be paid by the first available means whether by health insurance, med pay or settlement of your case. Should an overpayment be made and you have a credit balance on your account a refund will be issued to either you or the appropriate party.

I UNDERSTAND, AGREE TO AND WILL ABIDE BY ALL OF THE ABOVE.

Patient Name or Responsible Party: _____
Print Name

_____ Date:_____
Signature

Witness: _____ Date:_____
Signature

Regional Medical Group

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth: _____

I HAVE RECEIVED THIS PRACTICE'S Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of uses and disclosures that are prohibited or material limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to ammend protected health information.
    - The right to received an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

The practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices upon request.

Signature: _____ Date:_____

Relationship to Patient (if signed by a personal representative of Patient): _____

Patient Name: _____ Date: _____

DUTIES UNDER DURESS

Are there day to day activities which are painful or difficult for you to perform as a result of your injuries?

☑ Check all those that apply & write in the reason why you have difficulty performing the activity.

FOR DOCTOR USE

☐ **Work**	**Reason for the difficulty**	**Duration**

☐ **Studies/School**	**Reason for the difficulty**	**Duration**

	Domestic Duties	**Reason for the difficulty**	**Duration**
☐	Vacuuming		
☐	Taking care of children		
☐	Dishes/Dusting/Laundry		
☐	Preparing meals		
☐	Personal Care/bathing, dressing		
☐	Other		
☐	Other		

	Household Duties	**Reason for the difficulty**	**Duration**
☐	Mowing/Yard work		
☐	Transporting family		
☐	Shopping		
☐	Taking out trash		
☐	Other		
☐	Other		

LOSS OF ENJOYMENT

Are there areas of your life which you normally would be enjoying but are currently not enjoying, as a result of your injuries?

	Hobbies/Recreation	**Reason for the difficulty**	**Duration**
☐	Jogging		
☐	Dancing		
☐	Shopping		
☐	Traveling		
☐	Working Out		
☐	Other		
☐	Other		

	Sports	**Reason for the difficulty**	**Duration**
☐	Social		
☐	Competitive		
☐	Other		
☐	Other		

	Sexual Relations	**Reason for the difficulty**	**Duration**
☐	Other		
☐	Other		
☐	Other		

Regional Medical Group

RELEASE OF X-RAYS AND MEDICAL RECORDS

Date _____

Re: Patient _____

DOB: _____

I, _____, request the release of my x-rays and/or

Medical Records from _____.

I release _____ from any

and all claims resulting from the Release, as I realize they are part of your permanent records.

Signed _____

SSN _____

Witness _____ Date _____

5335 Roswell Road, N.E., Atlanta, GA 30342
Office: 404.943.9996 Fax: 404.943.9975