Salem Naturopathic Clinic, P.C.
1305 Broadway Street NE • Salem, OR 97301 • ph. 503 364-1441 • fax 503 364-9924

Motor Vehicle Accident Intake Form

Name of Patient:	
Date of Birth:	
Insurance Company:	
Address of Insurance Co:	
Phone of Insurance Co:	
Policy Number:	
Claim Number:	
Date of Loss:	
Time of Loss:	
State in Which Loss Occurred:	
Adjuster's Name:	
Adjuster's Phone Number:	

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Motor Vehicle Accident Financial Policy

This Motor Vehicle Accident (MVA) Financial Policy outlines financial terms and conditions specifically related to payment for the treatment of your MVA related injury. All other terms and conditions of our general Financial Policy, which you also signed, will apply.

Motor Vehicle Accident

- We will bill your motor vehicle insurance carrier. You must provide us with the information needed in order to bill by completing the attached Intake Form.
- In the event that your claims are denied by your motor vehicle insurance carrier, the personal injury protection benefits are exhausted or you receive a settlement, any balance on your account becomes due in full within 30 days.
- In the event that your claims are denied by your motor vehicle insurance carrier or the personal injury protection benefits are exhausted, we ***may*** be able to file your claim with your personal health insurance carrier. Though we may attempt to bill your personal health insurance carrier, there is no guarantee that they will pay the claim.
- We will not accept an attorney's 'letter of protection' for claims being disputed or in litigation and payment will be collected at time of service in these cases.
- Missed appointment fees cannot be billed to your motor vehicle insurance carrier. You will be personally responsible for paying these fees. Please see general Financial Policy for full details.

Regardless of the outcome of your Motor Vehicle Accident claim against an insurance company or litigation you might pursue related to your MVA claim, you are ultimately personally responsible for payment of any services provided by Salem Naturopathic Clinic, PC. Please see our general Financial Policy for payment terms.

Motor Vehicle Accident Financial Policy (Cont.)

In the event that my Motor Vehicle Accident claim is denied or my benefits exhausted, my preference would be the following (please select one):

	I would like Salem Naturopathic Clinic to attempt to bill my personal health insurance for this claim. My insurance information is: Insurance Carrier: ______________________ Policy Number: ______________ Group Number: ______________ Mailing Address for Claims: ______________________ Name of Insured: ______________ Date of Birth of Insured: __________ Relationship to Insured: ______________________
	I would NOT like Salem Naturopathic Clinic to attempt to bill my personal health insurance for this claim.
	I would like to decide this later. I will contact Salem Naturopathic Clinic prior to my claim being denied.

I have read and understand the Motor Vehicle Accident Financial Policy and agree to abide by its guidelines:

______________________ ______________
Patient name (printed) Date

______________________ ______________
Patient/Guardian Signature Relationship to Patient

Salem Naturopathic Clinic, PC

Automobile Crash History Form

Please Complete All Questions On Both Sides of This Form:

Name:______________________ Today's Date:______________

Date of Crash: ______________ Time:__________ ☐am ☐pm Location:______________

Road conditions at the time of crash: ☐ Wet ☐ Dry ☐ Icy ☐ Snow ☐ Other:______________

Describe crash in your own words: ______________________________

You were: ☐ Driver; ☐ Passenger; ☐ Pedestrian Passenger position: ☐ Front; ☐R. rear; ☐ L. rear ☐ Mid-rear

Were you on the job at time of crash? ☐ Yes ☐ No Employer's Name: ______________

Name(s) of people in your car: 1.______________ 2.______________ 3.______________

List the year, make and model of the vehicle you were in: Year:__________ Make:__________ Model:__________

Was your car stopped at the time of impact? ☐ Yes ☐ No If No, the estimated speed of vehicle you were in:__________MPH

If your vehicle was moving at time of impact, was it: ☐ Slowing Down ☐ Speeding Up ☐ Maintain Steady Speed

Estimated Damage to the vehicle you were in: $ ______________ Who performed estimate? ______________

List the year, make and model of the other Vehicle involved in the crash:

Year:__________ Make:__________ Model:__________

The impact was from: ☐Front; ☐Right Side; ☐Left Side; ☐Rear At impact you were facing: ☐forward; ☐ right; ☐ left

Were hands on steering wheel? ☐ Yes ☐ No Foot on brake? ☐ Yes ☐ No Seat belts on? ☐ Yes ☐ No

Position of headrest? ☐ High ☐ Middle ☐ Low Shoulder/lap combination? ☐ Yes ☐ No Did Seat Break? ☐ Yes ☐ No

If you have an airbag in your car, did it inflate on impact? ☐ Yes ☐ No ☐ N/A

Were you aware of the approaching crash prior to impact or were you surprised? ☐ Aware ☐ Surprised

Were you braced for impact? ☐ Yes ☐ No How did you brace? ______________

Did you receive any injury or bruise from the seatbelt or strike other parts of vehicle? ☐ Yes ☐ No

If Yes, Describe:______________

Did you experience a flash of light or a feeling of explosion in your head? ☐ Yes ☐ No ☐ Can't remember

Were you unconscious? ☐ Yes ☐ No ☐ Can't remember If yes, how long?__________

Immediately following the crash, did you become: ☐ Confused ☐ Disoriented ☐ Light Headed

☐ Dizzy ☐ Nauseous ☐ Blurred Vision ☐ Ring in Ears ☐ Other:__________

How long did the above symptom last: ______________

Was there police investigation at scene? ☐ Yes ☐ No Citation issued? ☐ Yes ☐ No To whom?__________

Did you go to a hospital/emergency center? ☐ Yes ☐ No If yes, where:__________ when:__________

How did you get to hospital?______________ Released same day? ☐ Yes ☐ No If no, when?__________

Treatment rendered:______________

Addition Studies: ☐ X-ray __________ ☐ CT / MRI __________ ☐ Other: __________

Doctor's recommendation/referral:______________

Other Dr.'s name:__________ Date:__________ Treatment:__________

Dr.'s name:__________ Date:__________ Treatment:__________

Dr.'s name:__________ Date:__________ Treatment:__________

Home Care Remedies Since Injury:

☐ Rest: Date Started:__________ Duration:__________ Details:__________

☐ Ice/heat Date Started:__________ Duration:__________ Details:__________

☐ Exercise: Date Started:__________ Duration:__________ Details:__________

☐ Medication: Date Started:__________ Duration:__________ Details:__________

☐ Other: Date Started:__________ Duration:__________ Details:__________

☐ Time loss: Date Started:__________ Duration:__________ Details:__________

Occupation:__________ Duration:__________ Details:__________

Duties affected by injuries:__________ Requirements:__________

Any household duties affected by injuries: ______________

Patient Name: ______________________________

CHECK ANY SYMPTOMS YOU HAVE NOTICED SINCE THIS CRASH:

		L	R			
☐ Headache	☐ Hip Pain	○	○	☐ Shortness of Breath	☐ Diarrhea	☐ Chest Pain
☐ Neck Pain	☐ Leg Pain	○	○	☐ Fatigue	☐ Feet Cold	☐ Heavy Head
☐ Neck Stiff	☐ Knee Pain	○	○	☐ Depression	☐ Hands Cold	☐ Upset Stomach
☐ Mid-back Pain	☐ Ankle Pain	○	○	☐ Lights bother eyes	☐ Regional Swelling	☐ Constipation
☐ Low-back Pain	☐ Foot Pain	○	○	☐ Face Flushed	☐ Uncoordinated	☐ Urinary Difficulties
☐ Anxiety	☐ Shoulder Pain	○	○	☐ Pins and Needle in arm	☐ Loss of Balance	☐ Sexual Dysfunction
☐ Jaw Pain	☐ Arm Pain	○	○	☐ Pins and Needle in leg	☐ Fainting	☐ Vomiting
☐ Jaw Clicking	☐ Elbow Pain	○	○	☐ Numbness in Fingers	☐ Loss of Smell	☐ No longer care about things
☐ Ears Ring	☐ Wrist Pain	○	○	☐ Numbness in Toes	☐ Loss of Taste	☐ Fluid in Ears
☐ Restlessness	☐ Hand Pain	○	○	☐ Irritable	☐ Emotional difficulty	☐ Relationship difficulty
☐ Difficulty with Memory	☐ Difficulties Sleeping			☐ Difficulty thinking	☐ Intolerance to Heat	☐ Intolerance to Alcohol
☐ Intolerance to Cold	☐ Forget ATM/phone #s			☐ Writing problems	☐ Reading problems	☐ Personality Changes
☐ Difficulty concentrating	☐ Loss of attention			☐ Dizzy	☐ Blurred Vision	☐ ________
☐ ________	☐ ________			☐ ________	☐ ________	☐ ________

When did the symptoms first appear? ______________________________

Which of the above symptoms were present and active within one year prior to this crash? ______________________________

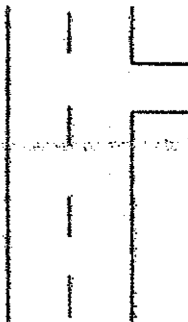
Have you ever received a concussion prior to this crash? ☐ Yes ☐ No If yes, when/ Describe ______________________________

Any previous Auto collisions? ☐ Yes ☐ No If yes, when/ Describe: ______________________________

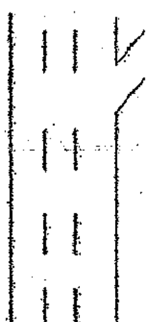
Any other comments about collision or injuries: ______________________________

Intersection

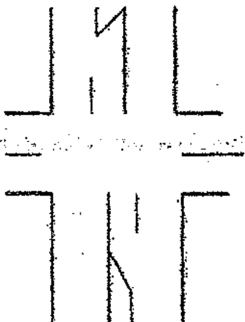
Straight Road/ Driveway



Freeway



Intersection with turn lane



Your Auto Insurance Company: ____________________ Address: ____________________

Policy #: ____________ Expiration Date: ____/____/____ Claim # for this accident: ____________________

Have you filed a Personal Injury Protection application to <u>your</u> insurance company on this claim? ☐ Yes ☐ No When? ________

Other driver's Insurance Co.: ____________________ Address: ____________________ Policy #: ____________

Do you have an attorney who has advised you in this case? ☐ Yes ☐ No Name: ____________ Phone: ____________

I hereby attest that the above information is true and correct to the best of my knowledge.

Patient Signature: ______________________________ Date: ____________

Interpreted by: ______________________________

Rev March 06