Prairieland Wellness Center of McLean County
PERSONAL INJURY QUESTIONNAIRE

Name _____ Phone_____

Mailing Address _____City _____

State _____ Zip _____ Age _____ Birthday _____ / _____ /_____ Gender_____

Person to contact in an emergency _____ Phone _____

AUTO INSURANCE – (We do not accept 3rd party insurance)

Responsible Party's Name _____Phone #_____

Address _____ City _____ State _____ Zip _____

Auto Insurance Co (Med Pay) _____Claim # _____

Claim Representative _____ Phone_____

Fax #_____

NATURE OF ACCIDENT:

1. Date of Accident _____ Time of Day _____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____ Were you wearing seat belts? _____
4. What direction were you headed: ( ) North ( ) East ( ) South ( ) West
   on (name of street): _____
5. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street): _____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Approximate speed of your car _____mph, …other car _____ mph
8. Were you knocked unconscious: ( ) Yes ( ) No If yes, for how long? _____
9. Were police notified? ( ) Yes ( ) No
10. In your own words, please describe accident: _____
    _____
    _____
    _____
11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No if yes, please describe in detail:_____
    _____
    _____.
12. Please describe how you felt:
    DURING the accident: _____
    IMMEDIATELY AFTER the accident: _____
    LATER THAT DAY _____
    THE NEXT DAY _____

13. What are your PRESENT complaints & symptoms: _____

_____

_____

14. Do you have any congenital (from birth) factors that relate to this problem? ( )Yes ( ) No If yes, please describe:

_____

_____

15. Do you have any previous illnesses that relate to this case? ( ) Yes ( ) No If yes, please describe:

_____

16. 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 injuries received: _____

_____

17. Where were you taken after the accident? _____

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name & Phone #: _____

What type of treatment did you receive? _____

19. Since this injury occurred, are you symptoms: ( ) Improving ( ) Getting Worse ( ) Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness In Fingers	☐ Ears Ring	☐ Diarrhea	

Symptoms Other Than Above: _____

21. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe in detail:

_____

_____

_____

22. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete this question:

Last Day Worked : _____ Type of Employment _____

Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving: _____

23. Other pertinent information:

_____

_____

_____

_____ _____

Patient or Guardian's Signature **Date**

_____

Printed Name if Guardian

Craig A. Bowars DC, PLLC
PERSONAL INJURY PAYMENT POLICY

Med-Pay Information

If you have been involved in an automobile accident, **we will need a copy of your photo ID**, **a copy of your auto insurance card or the name of your insurance company**, **their phone number**, and the **claim #**. We will verify that you have medical payments as part of your coverage. **If you do, we will bill your auto insurance for your care.**

If you were a passenger in someone else's car, we will need the above information about their auto insurance to confirm that they have medical payment coverage for you. We will bill them for your care.

*You (or the driver) pay for this benefit and it DOES NOT increase your premiums.

If another party is at fault, we will submit the claim to your auto insurance company and they will pay us directly. Your insurance company will be reimbursed from the responsible parties insurance upon settlement of the claim.

If you were at fault, your auto insurance simply pays your bills with no reimbursement to them.

If you were hit by an uninsured motorist and you have uninsured motorist coverage, your insurance will pay for you care at the conclusion of treatment.

If insurance does not cover all the bills incurred, you will be responsible to pay our clinic for the balance due.

This office DOES NOT accept 3rd party liens. A 3rd party lien is a type of case where the other party (insurance of the person who hit you) accepts responsibility for your medical care, but DOES NOT pay us directly. They typically refuse to pay us directly citing that their responsibility is to you, the person their insured hit, not to the health care providers who treated you. Since we are unable to secure a direct method of payment, we do not accept these circumstances. **However, at times, a case may *default* to a 3rd party lien situation. In the event of this, the following explains how those cases are handled:**

3rd Party Financial Agreement

I understand that I am to resolve my case with the 3rd Party payor within 90 days following the completion of my medical care, at which time I am to pay Craig A. Bowars DC, PLLC per the terms stated below. If settlement is not made within 90 days following the completion of medical care, I become personally responsible for payment of my medical bill which is due at that time.

Terms:

I fully understand that I am to pay Craig A. Bowars DC, PLLC by cash, check, money order or cashier's check (no credit cards accepted) for the balance from my Personal Injury case within 5-10 days upon receipt of my settlement check from the Third Party insurance company.

***Our office must be notified on a regular basis as to the status and progress of settlement of your claim. If, for some reason, there are extenuating circumstances that prevent you from settling within 90 days, our office should have been receiving routine updates in order to justify an extenuating circumstance.**

***If a balance continues per the terms stated above, a 1% interest penalty will be added to your account on a monthly basis along with any collection fees.**

As with any case, if we are unable to secure payment from the auto insurance, attorney, etc., or they have failed to make full payment and a balance is due, you understand that you are responsible for payment in full.

Patient's Full Name (printed) _____

Patient/Guardian Signature: _____ Date: _____

CRAIG A. BOWARS DC, PLLC

PERSONAL INJURY

FINANCIAL POLICY STATEMENT / DR.'S LIEN

I hereby acknowledge that I am receiving, or am about to receive, health care services from Craig Bowars, DC, and/or his staff. **I understand that I am financially responsible for all services, nutritional supplements, and medical supplies I receive from Dr. Bowars and/or his staff. I agree to pay for all nutritional supplements at the time I receive them with the understanding that I will be reimbursed if insurance also pays for the nutritional supplements.** I understand that Dr. Bowars is willing to wait for payment for his services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim.

I understand that:

1. If it is determined that an insurance company is not obligated to pay for the services rendered by Dr. Bowars and/or his staff, or if the insurance company involved refuses to acknowledge an assignment to the doctor, or make other provisions for the protection of the interest of the doctor, I agree to pay the entire balance of my account within ninety (90) days after my most recent office visit with Dr. Bowars.

2. If a liability claim exists, but my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney, then payment for all services rendered by Dr. Bowars and/or his staff will be due and my bill will be paid in full as soon as the liability claim is settled.

3. If an insurance company pays me directly for services rendered by Dr. Bowars and/or his staff, I am obligated to turn that payment over, upon receipt by me, to Dr. Bowars to cover any outstanding balance on my account. If I violate this agreement and do not send the payment to Dr. Bowars, a 1% per month interest charge will be added to my account until it is paid in full.

Patient's Full Name (printed): _____

Patient/Guardian Signature: _____ Date: _____

Authorization to Release Information: I authorize the release of any medical or other information necessary to my/other party's insurance company or attorney if deemed necessary, either by my/other party's insurance company, attorney or my/other party's physician at this clinic in order to process a claim.

Patient/Guardian Signature: _____ Date: _____

Nutritional Informed Consent

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment, or Prevention of disease." A vitamin is not a drug. Neither is a mineral, a trace element, an amino acid, an herb, or homeopathic remedy. Although a vitamin, a mineral, a trace element, an amino acid, an herb or a homeopathic remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone. Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

Patient/Guardian Signature: _____ Date: _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

Patient Name: _____ DOB: _____

Insurance Company: _____

PI Claim #: _____

I hereby instruct the above named insurance company to pay by check made out to and mailed directly to:

Craig A. Bowars DC, PLLC
Prairieland Wellness Center of McLean County
1415 Croxton Avenue
Bloomington, IL 61701
(309) 829-3330

for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy or by a 3rd party payor who would otherwise pay me directly, as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY AND/OR CLAIM.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by the insurance policy.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance.

Date: _____

Signature of Claimant/Guardian: _____