Soma Chiro & Functional Medicine
AUTO ACCIDENT QUESTIONNAIRE

Name_____ Date_____

Date of Accident_____

Brief description of Accident (i.e. rear-ended, head on, side impact, etc.) _____

_____

_____

Describe any secondary collisions (i.e. pushed into vehicle in front of you) _____

_____

Do you recall striking anything inside the vehicle? (i.e. knees on dashboard, head on windshield)

NO YES _____

What type of vehicle were you in? _____ Estimated Speed_____

What type of vehicle was the other driver in ?_____ Estimated Speed_____

Describe damage to your vehicle Light Moderate Heavy Damage Estimate _____

After the accident was your vehicle Drivable Not drivable

Were you Driver Passenger - Sitting:_____

At the time of the accident: Visibility was Good Poor

Time of Day Daylight Night

Road conditions Dry Wet Snow/Ice

At the time of impact:

Were you looking Toward Left Straight ahead Toward Right Up Down

Was your foot on the brake? Yes No

Were you Braced for Impact Unaware of Impending collision

Were you wearing a seatbelt? Yes No Did your airbag deploy? Yes No

Was your headrest Adjusted properly Not Adjusted Don't Recall

Stop Here. Lower section for doctor's evaluation

_____

_____

MIC1 Subjective symptoms 10pts.
MIC2 Symptoms, Loss of ROM 50pts.
MIC3 Symptoms, ROM & Neuro 90pts.

Modifiers

Canal Size 10-12 mm 20

_____

Kyphotic Cervical Curve 15
Straightened Cervical Curve 10
Blocked/ Fused Segments 15
Loss of Consciousness 15
Pre-existing DJD 10

Hyper/Hypo Mobility on Flex./Ext.

10-30 Excellent
35-70 Good
75-100 Poor
105-125 Guarded
130-165 Unstable

Complicating Health/Lifestyle Factors:

_____

_____

Soma Chiro & Functional Medicine
2345 Rice Street Suite 155, Roseville, MN 55113
Phone: (651) 528-7978
Fax: (651) 528-7941

NOTE – Please fill out ONLY if there was an accident involved

PATIENT ACCIDENT INFORMATION

(Please Print All Answers)

Name _____ Age _____ Sex _____ Date _____
Home Address _____ City/State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Best time to call _____ Which # _____ Email _____
Social Security # _____ Birthdate _____ Employer _____

HEALTH INSURANCE INFORMATION

Name of insurance company _____ Group Number _____
Name of insured (policy holder) _____ Policy Number _____
Insured birthdate _____ Relationship to insured _____

ACCIDENT INSURANCE INFORMATION

Name of YOUR auto insurance company _____
Agent name _____ Agent number _____
Accident claim number _____

Name of LIABLE insurance company _____ Phone number _____
Insured name _____ Claim number _____
Attorney name _____ Phone number _____

WORK OR INJURY INSURANCE INFORMATION

Employer or responsible party _____
Claim number _____
Contact person _____ Phone number _____

Please provide the receptionist with your driver's license to be copied for your medical records.

Welcome to Soma Chiro & Functional Medicine, where we offer chiropractic, rehabilitation, nutrition, and functional medicine services. We will strive to help improve and/or restore your health but there are no guarantees or promises of improvement or complete recovery.

Your signature on this document fully authorizes our staff and doctors to perform any examinations, diagnostic tests and/or treatments, as we may consider medically necessary and to release all information pertinent to your health, insurance or benefits to any & all-applicable parties on your behalf.

Our office and staff are committed to provide to all patients regardless of race, color, class, age, gender, national origin, disability, religious or political beliefs, quality healthcare services delivered with dignity and concern. HIPAA requires that we have you read and sign the federally governed Health Care Privacy Notice. The Health Care Privacy Notice will explain when, where, and why your confidential health information may be used, stored, and/or shared and is a part of this document that is a permanent part of your medical records stored here in this office or it's computer systems. You may receive a free photocopy of this document that you've just signed by asking one of our staff.

You signature on this document confirms that you have read, understand, and agree to comply with all terms and conditions of the Health Care Privacy Notice and all policies, consents, terms, and conditions regarding your to this Facility and that you grant the physicians and/or staff of this Facility to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of your bill and/or issues that concerns this Facility operations and responsibilities. Please direct any questions or concerns to a member of our staff. We encourage questions and/or concerns to avoid misunderstandings. Our office hours are Mon-Thurs 9am-1pm and 3pm-7pm, but we can accommodate your schedule if given advance notice. If you must miss an appointment please notify us within 24 hours or as soon as you are able to avoid a cancellation fee of $25.

Patient Name (Print) _____

Signature (If minor, parent/guardian must sign) _____ Date _____

Letter of Protection

THIS AGREEMENT, entered into this date and between, _____"Patient", and Dr. Senyi Ly DC, Soma Chiro LLC, called "the doctor". Acknowledged and signed by the Doctor, Patient, & or (as in the case of minors), Parent and/or Guardian.

WHEREAS Patient desires to receive chiropractic services from the doctor and desires to assign certain rights and benefits to the doctor as consideration for the doctor awaiting payment of such benefits.

Accordingly, it is hereby agreed:

A. Patient hereby authorizes the doctor to furnish a full report and records regarding case history, examination, diagnosis, treatment and prognosis, x-rays, laboratory reports and the results of all tests of any type or character of patients such persons as the doctor deems appropriate.

B. Patient's assigns to the doctor any and all benefits payable by Patient's insurance or health care plan(s) as a result of charges incurred by Patients for services rendered by the doctor. Patient also assigns to the doctor any and all contractual rights Patient has against insurance company, health care benefit plan, or any other party possibly liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by the doctor. There is a 9% simple annual interest on all monthly balances due, which begins upon release from initial visit. Interest is calculated on each monthly balance.

C. Patient fully understands that Patient is directly and fully responsible to the doctor for all bills submitted for services rendered and that this agreement is made solely for additional protection and consideration for awaiting payment. A patient further understands that such payment is not contingent on any settlement, claim, judgment, or verdict which Patients may eventually recover. In the event of non-payment by any insurance company, health care benefit plan, or any other party possible liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by the doctor, Patient agrees to be responsible for any such outstanding balance, including simple accrued interest rate of 9% annually, all attorney's fees, collection expenses and court costs.

D. Patient fully understands that the lien and assignment given to the doctor herein is irrevocable.

E. By executing this agreement, Patient hereby instructs and directs any attorney-representing Patient to honor the above lien and assignments and make payment under the lien and assignment directly to the doctor. Patient directs that attorney be bound by this lien and treat it, irrevocably, as an assignment due to the doctor. The

doctor is relying upon this lien, assignment and directive to any attorney, and as a result of such reliance, the doctor is providing care and treatment for which this lien, assignment and directive provides security for payment. Moreover, Patient agrees that the doctor is to be viewed as a third party beneficiary of this direction to Patient's attorney and it is Patient's intent to impose upon Patient's attorney an obligation to comply with the terms of this directive.

F. Patient hereby directs all insurers and other persons possibly responsible for Patient's healthcare costs to make all payments for healthcare services rendered by the doctor directly to the doctor.

G. Patient agrees that in the event Patient receives any check, draft, or other payment subject to this agreement, Patient agrees to act as fiduciary agent for the doctor and will immediately (within 1 business day) deliver said check, draft, or payment to the doctor to be applied to Patient's debt for services rendered.

H. Patient hereby appoints the doctor as Patient's true and lawful attorney, irrevocable, and with full power of substitution, for Patient and in Patient's name, to ask, demand, sue for, collect, endorse, sign and receive proceeds from insurance, other health benefits, and third party claims relating to services rendered to Patient by the doctor. The doctor is not obligated or compelled to exercise such powers but may do so in the doctor's sole discretion. Patient agrees to fully cooperate with the doctor in collecting said amounts. Any negotiated agreement to reduce any amounts owed to doctor is 100% and entirely at doctors' direction.

I. The doctor agrees to submit a copy of this agreement with the initial claim form(s) which the doctor submits to third party payor(s) as notice to the third party payor(s) of the assignment and other agreements contained herein. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in Patient's file and may be picked up by the Patient, upon reasonable request and during normal business hours, or upon written request by Patient, be mailed to designated address.

J. Patient hereby authorized the doctor to receive a complete copy of Patient's insurance policy, including any endorsements, conditions, limitations or exclusions.

K. A copy of these documents shall be as binding as the document bearing the original signatures.

_____ _____

Date Patient's, Parent, and/or Guardian Signature

_____ _____

Date Doctor signature, Dr. Senyi Ly DC, Soma Chiro LLC

Rev 9/2018

Soma Chiro & Functional Medicine
2345 Rice Street Suite 155
Roseville, MN 55113
651-528-7978

Irrevocable Escrow Instruction and Agreement

The undersigned patient (hereinafter "Patient") in order to induce Soma Chiro & Functional Medicine (hereinafter the "Provider") to extend credit to the Patient, hereby irrevocable, instruct my attorney and escrow agent, to pay to Provider the full amount of any bill for services rendered by the Provider, from the proceeds of my personal injury settlement or award within ten (10) days of receipt by him of same, excepting time for any negotiable instrument to clear.

This escrow instruction and agreement is irrevocable by me and is being used to include the Provider to provide continued medical services to me resulting from my accident.

Patient Signature _____ Date _____
Patient Name _____
Patient Address _____

Understood and agreed to by:

Soma Chiro & Functional Medicine

Provider Signature _____ Date_____