BEST

REGISTRATION FORMS

PERSONAL INFORMATION

First name: | MI: | Last name: | Date:

Date of birth: | Age: | Social Security#:

Driver's license#: | Email: | Home phone#: | Cellphone#:

Current mailing address: | City: | State: | ZIP code:

Previous address, if less than 6 years at current: | City: | State: | ZIP code:

Sex: ☐ Male ☐ Female ☐ Intersex Marital status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

If you are married or otherwise partnered, what is the person's name?

Race:

☐ Black/African-American ☐ White ☐ Native Hawaiian/Pacific Islander ☐ American Indian ☐ Hispanic or Latino

☐ Decline to answer ☐ Asian ☐ Alaska Native ☐ Other:

Ethnicity:

☐ Not Hispanic or Latino ☐ Decline to answer ☐ Hispanic or Latino ☐ Unknown

Preferred language:

☐ English ☐ Spanish ☐ Decline to answer ☐ Other

EMERGENCY CONTACT INFORMATION

I authorize BEST Centers of America - Ohio LLC to VERBALLY discuss my selected information with the following people, including translation from/to another language:

Contact name 1: | Relationship: | Home phone#: | Cellphone#:

Street address: | City: | State: | ZIP code:

Contact name 2: | Relationship: | Home phone#: | Cellphone#:

Street address: | City: | State: | ZIP code:

By selecting the following options and signing, I authorize BEST Centers of America - Ohio LLC to discuss the following information with my emergency contact(s)

☐ My appointment information ☐ My billing and payment information ☐ My lab/test results ☐ My location within the facility

☐ My medical information (including symptoms, diagnosis, medication and treatment)

Cancellation of this authorization must be submitted in writing.

SIGNATURE NEEDED

Patient/guardian signature: | Printed name: | Date:

PATIENT HISTORY

Have you ever used any form of nicotine or tobacco? ☐ Yes ☐ No If so, have you received counseling to stop tobacco use? ☐ Yes ☐ No

Type of tobacco	Daily amount	Years used	Age started	Date ended
Cigarettes				
Cigar				
Pipe				
E-cigarette				
Chewing				
Smokeless				
Snuff				
Nicotine patch				

Do you drink coffee, tea or soda? ☐ Yes ☐ No

If you answered yes:

How many cups per day? _____ Per week? _____

Do you drink alcohol? ☐ Yes ☐ No

If you answered yes:

How many drinks per day? _____ Per week? _____

MEDICAL HISTORY

Please indicate if you have any of the following and explain below:

☐ Angina ☐ Headaches/migraines ☐ Pacemaker/defibrillator ☐ Arthritis ☐ Heart attack
☐ Prior infections ☐ Asthma ☐ Heart murmur ☐ Pulmonary (lung) disease ☐ Bleeding disorders
☐ Heart rhythm abnormalities ☐ Rheumatic fever ☐ Cancer ☐ Hepatitis ☐ Seizures
☐ Cholesterol disease ☐ High blood pressure ☐ Skin disorders ☐ Congestive heart failure ☐ HIV/AIDS
☐ Sleep apnea ☐ Coronary heart disease ☐ Kidney/bladder disease ☐ Strokes/TIA ☐ Depression/anxiety
☐ Liver disease ☐ Tremors ☐ Diabetes ☐ MRSA ☐ Thyroid disease
☐ Fibromyalgia ☐ Multiple sclerosis ☐ Tuberculosis ☐ Gastrointestinal disease ☐ Nervous system disease
☐ Vascular disease ☐ GERO ☐ Osteoporosis ☐ Other

If any of the above was checked, please explain:

_____

_____

ACTIVITY/LIFESTYLE MODIFICATIONS

What is your primary concern?

_____

How long have you had this problem?

_____

How did this problem start (for accident or workers' compensation, please complete the necessary section on page 2.)

_____

_____

What modifications have you made to your normal daily activities? _____

Percentage of relief from these changes: _____

Date range of these changes (MM/YY): _____

Please list any restrictions you have:

_____

Are you able to perform household chores? ☐ Yes ☐ No

Are you able to sit for long periods of time? ☐ Yes ☐ No

Are you able to stand for long periods of time? ☐ Yes ☐ No

Does your pain interfere with your daily job functions? ☐ Yes ☐ No

If yes, please explain:

_____

_____

Primary physician name: _____ Phone#: _____

Specialist name: _____ Type of physician: _____ Phone #: _____

INSURANCE INFORMATION

We MUST obtain this information to coordinate with your insurance company and provide the best care.

Primary insurance: | Insurance company's phone#: | Policyholder's name (as on card): | Policyholder's relationship:

Insurance claims address: | Policyholder's DOB: | Policyholder's SSN:

Member ID/policy#: | Group#: | Employer Name | ☐ None ☐ Retired

Employer Address | City | State | Zip | Employer Phone

Secondary insurance: | Insurance company's phone#: | Policyholder's name (as on card): | Policyholder's relationship:

Insurance claims address:

Policyholder's DOB: | Policyholder's SSN: | Member ID/policy#: | Group#:

Tertiary insurance: | Insurance company's phone#: | Policyholder's name (as on card): | Policyholder's relationship:

Insurance claims address:

Policyholder's DOB: | Policyholder's SSN: | Member ID/policy#: | Group#:

ATTORNEY INFORMATION

If your condition is the result of an accident or other injury for which you are represented by an attorney, please provide the following information for your attorney:

Name: | Phone#:

Street address: | City: | State: | ZIP code:

AUTO INSURANCE

If your condition or injury is the result of an automobile accident, please provide the following information about the automobile insurance involved:

Company name: | Claim#: | Phone#: | Date of accident:

Name of policyholder: | Relationship: | State accident occurred in: | Adjuster name:

Have auto benefits been exhausted? ☐ Yes ☐ No | If yes, enter date benefits exhausted:

PATIENT INSURANCE ELECTION

I, _____ am seeking medical treatment for injuries related to a personal injury accident at the recommendation of my treating physician.

I acknowledge the following by initialing my selection:

_____ I do not have health insurance coverage. _____ I do have or have limited health insurance coverage. _____ I elect not to use my health insurance.

I fully understand and acknowledge that due to the risky nature of personal injury litigation, the cost of treatment and care can be higher than other forms of healthcare reimbursement rates.

Patient's Signature | Date | Witness Signature | Date

PATIENT HISTORY

Please bring all medical records for the treatment of your neck and back pain.

Physical therapy

Provider name:_____ Phone#: _____

Street address:_____ City: _____ State: _____ ZIP code: _____

Percentage of relief:_____ Start date (MM/YY): _____ End date (MM/YY): _____

If discontinued before 6- 12 weeks, state why: _____

Pain management care

Physician name: _____ Phone#: _____

Street address:_____ City: _____ State: _____ ZIP code: _____

Percentage of relief:_____ Start date (MM/YY): _____ End date (MM/YY): _____

Injection (steroid, epidural, diagnostic, facet, radio frequency ablation)

Physician name: _____ Phone#: _____

Street address:_____ City: _____ State: _____ ZIP code: _____

Date of first injection (MM/YY): _____ Percentage of relief: _____

Date of second injection (MM/YY):_____ Percentage of relief: _____

Date of third injection (MM/YY):_____ Percentage of relief: _____

Chiropractic care (traction, inversion, manipulation, decompression)

Physician name: _____ Phone#: _____

Street address:_____ City: _____ State: _____ ZIP code: _____

Percentage of relief:_____ Start date (MM/YY): _____ End date (MM/YY): _____

If discontinued before 6- 12 weeks, state why: _____

Massage

Provider name: _____ Phone#: _____

Street address:_____ City: _____ State: _____ ZIP code: _____

Percentage of relief:_____ Start date (MM/YY): _____ End date (MM/YY): _____

If discontinued before 6- 12 weeks, state why: _____

Acupuncture

Place of service: _____ Phone#: _____

Street address: _____ City: _____ State: _____ ZIP code: _____

Percentage of relief:_____ Start date (MM/YY): _____ End date (MM/YY): _____

Exercise program

Type of program: _____ Physician ordered?: ☐ Yes ☐ No

Percentage of relief:_____ Start date (MM/YY): _____ End date (MM/YY): _____

If discontinued before 6- 12 weeks, state why: _____

Heat therapy

Percentage of relief:_____ Start date (MM/YY): _____ End date (MM/YY): _____

Ice therapy

Percentage of relief:_____ Start date (MM/YY): _____ End date (MM/YY): _____

Spinal or Orthopaedics Surgery #1

Surgeon name: _____ Phone#: _____

Street address: _____ City: _____ State: _____ ZIP code: _____

Surgery performed: _____

Date (MM/YY):_____ Level:_____ Outcome: _____

Spinal or Orthopaedics Surgery #2

Surgeon name: _____ Phone#: _____

Street address: _____ City: _____ State: _____ ZIP code: _____

Surgery performed: _____

Date (MM/YY):_____ Level:_____ Outcome: _____

PATIENT HISTORY

Medications

Please provide your usage of nonsteroidal anti-inflammatory medications (NSAIDs such as ibuprofen, aspirin, naproxen).

Name and dose	Daily dosage	Last date taken	Length of time on medication
Ex: Advil 400 mg	Twice a day	4-1-2017	5 years

Pain medication

Are you currently taking pain medication? ☐ Yes ☐ No Percentage of relief medications provide: _____

If yes, please list dosage and frequency below. (Medications including but not limited to Percocet, oxycodone, hydrocodone, Norco, Lortab, Vicodin, Dilaudid, Hydromorphone, Fentanyl, Oxycontin, Oxymorphone, Opana, codeine, Tylenol #3 or #4.)

Name and dose	Daily dosage	Last date taken	Length of time on medication
Ex: Percocet 325 mg	Twice a day	4-1-2017	1 year, 6 weeks

Physician prescribing pain management: Phone#: Fax#:

Address: City: State: ZIP code:

Have you scheduled a follow-up appointment with your pain management physician after your surgery? ☐ Yes ☐ No

Do you need assistance transitioning off of pain medication after your surgery? ☐ Yes ☐ No

Other medications

Please clearly list below any medications you take in addition to your pain medication listed above.

Name and dose	Daily dosage	Last date taken	Reason for taking
Ex: Med name 20mg	Twice a day	4-1-2017	Cholesterol

Patient Pharmacy

Name: Phone:

Address: City: State: ZIP code:

PATIENT HISTORY

Supplements

Please clearly list below any herbs, vitamins or supplements you take.

Name and dose	Daily dosage	Last date taken	Reason for taking
Ex: Supplement name 20mg	Twice a day	4-1-2017	Immune support

FAMILY HISTORY

Place a check by any family conditions and fill in the rest of the row.

Mother= M, father = F, sibling= S, child = C, maternal grandparent= MG, paternal grandparent= PG

Condition (Please check)	Which family member?						Onset	Current family member condition
	M	F	S	C	MG	PG		
☐ Arthritis								
☐ Bleeding disorders								
☐ Cancer								
☐ Cholesterol disease								
☐ Coronary heart disease								
☐ Diabetes								
☐ Heart attack								
☐ High blood pressure								
☐ Kidney/bladder disease								
☐ Liver disease								
☐ Neuromuscular disease								
☐ Osteoporosis								
☐ Pulmonary disease								
☐ Stroke								
☐ Thyroid disease								

SURGICAL HISTORY

Please indicate if you have had any of the following procedures, conditions or surgery on any of these areas:

☐ Abdominal (stomach)	☐ Gallbladder	☐ Nerve stimulator or pump	☐ Anesthesia complications	☐ Hand
☐ Pacemaker/defibrillator	☐ Angioplasty/stents	☐ Hemorrhoids	☐ Prostate	☐ Appendix
☐ Hernia	☐ Shoulder	☐ Arm	☐ Hip	☐ Spine (neck/back)
☐ Breast	☐ History of dura leak	☐ Thyroid	☐ Chest/lung	☐ Knee
☐ Tonsil/wisdom teeth/adenoids	☐ Coronary artery bypass	☐ Leg	☐ Uterus/ovary	☐ Elbow
☐ Low back/lumbar spine	☐ Varicose veins	☐ Foot/Ankle	☐ Neck/cervical spine	☐ Wrist

If any of the above was checked, please explain:

ALLERGIES

Please clearly list any allergies, medical or nonmedical.

Type of allergy	Reaction	Severity (please check one)			
		Mild	Moderate	Severe	Life Threatening
Example: Penicillin	Hives, itching and rash				

MEDICATION ALERT LIST

(Please keep a copy for your reference.)

Continue these prescribed blood-thinning medications unless BEST Centers of America - Ohio LLC has been provided with written approval/permission from your doctor that you can stop the medication. If you are on any of these prescribed medications, speak to your Care Team nurse.

If you are diabetic: Consult with the doctor who treats your diabetes about your insulin dosage or other diabetic medication. You may experience an elevation in your blood sugar before, during and/or after surgery due to the stress of surgery and steroid medications used during the surgery. Please have a plan to address this with your local doctor who treats your diabetes so you are ready to handle elevations in your blood sugar while you are at BEST Centers of America - Ohio LLC. This could include additional checking of your blood sugar and additional insulin as needed. Our providers will check and treat your blood sugar before, during and after surgery. For your safety, we ask that you follow your regular doctor's instructions after you are released from BEST Centers of America - Ohio LLC. Please closely monitor your dietary intake to prevent blood sugar fluctuations.

BEST Centers of America - Ohio LLC will inform you of the exact date of your surgery. Medication instructions will be given after we are able to obtain written permission from your prescribing physician.

Please take time to review and sign to acknowledge that you understand the following Medication Alert List.

WARNING

THESE MEDICATIONS CAN ONLY BE STOPPED WITH APPROVAL OF YOUR PRESCRIBING PHYSICIAN.

- Aggrenox (aspirin/dipyridamole)
- Fragmin (dalteparin)
- Arixtra (fondaparinux)
- Innohep (tinzaparin)
- Aspirin (when prescribed by your physician)
- Lovenox (enoxaparin)
- Brilinta (ticagrelor)
- Plavix (clopidogrel)
- Coumadin (warfarin)
- Pletal (cilostazol)
- Eliquis (apixaban)
- Pradaxa (dabigatran etexilate)
- Xarelto (rivaroxaban)

By signing, I understand that approval must be obtained from my prescribing physician before stopping any of these medications before my surgery date. I understand that failure to follow the exact instructions regarding what day to take the last dose of these medications might result in postponement of my surgery.

SIGNATURE NEEDED

Patient/guardian signature: _____ Printed name: _____ Date: _____

LETTER OF PROTECTION

Patient Name: _____ Accident Date: _____ Initial Visit Date: _____

Accident Location State (check one): ☐ Ohio ☐ Kentucky ☐ Indiana ☐ Other: _____

I, the above-named Patient, do hereby authorize and direct my present and any future attorney(s) to honor this fee guarantee agreement. This Letter of Protection ("LOP") is made in favor of the above-named Medical Provider. The LOP shall serve to place a continuing lien on any proceeds I recover in any legal action or proceeding related to the above noted accident date.

Consideration. In consideration of the medical treatment provided, and the medical provider's willingness to wait until the conclusion of my legal case and finalization of applicable insurance obligations to pay for said medical treatment, I hereby grant a direct lien on any and all funds I may recover in any legal action or proceeding related to the above accident date.

Protection of Outstanding Charges. In the event that a financial recovery is made on my behalf by any person, attorney or other entity, in connection with any legal action or other proceeding related to the above accident date, I hereby direct and instruct my present, and any future attorney(s) representing me (including myself in a pro-se capacity) to withhold from said recovery, funds sufficient to pay the full outstanding balance of any bill(s) owed to the above-named Medical Provider, for treatment provided in connection with same. I understand that my Medical Provider has agreed to work with my Attorney, and as part of my settlement or verdict, to the extent allowed by applicable law, depending on the State in which the Accident occurred, may accept a reduced amount, or waive my outstanding balance altogether. I hereby irrevocably instruct my present and/or future attorney(s) not to disburse any settlement funds for any reason, including but not limited to attorney's fees, costs, and other medical liens, until my Medical Provider has been contacted and my financial responsibility obligations are resolved.

Patient Responsibility. I understand that it is my responsibility to advise each attorney representing me of the existence of this agreement. I further direct my present attorney(s) and any future attorney(s) to advise the Medical Provider, as soon as possible, about any funds that are recovered in connection with my case. I understand that under certain circumstances, I may not obtain any financial recovery and if that is the case, I am responsible for the payment of the Medical Provider's outstanding balance(s), and in such event, the remaining amounts are to be paid by the Patient.

Payment. All payments made pursuant to this agreement shall be made to:
BEST Surgery & Therapies
644 Eden Park Dr.
Cincinnati OH 45208

Enforcement. I further agree to be fully responsible for reasonable attorney's fees and costs, if any, that have been accrued by the Medical Provider in the pursuit of payment of my account. Also, that in the event of my failure to comply with the payment agreement, I understand the amount of balance due will be subject to a one percent (1%) per month service charge, or the maximum allowed by law.

Approval Required. This agreement becomes effective when the Patient signs the agreement below. This agreement does not need the approval of any present or future attorney for the Patient, however it is recommended that the Patient submit any forms to their attorney for review.

The parties agree that no party shall be considered the drafting party to this contract.

Patient's Printed Name: _____ Patient's Signature: _____ Date: _____

Attorney Signature: _____ Date: _____ RETURN VIA FAX: _____

-FOR KENTUCKY RESIDENTS ONLY-

No-Fault (PIP Coverage) Information

To the best of your (the patient and/or patients guardians) knowledge, what Personal Injury Protection (PIP) do you, or the owner of any vehicle in which you were a passenger on the accident date, have?

☐ Basic Coverage ☐ Extra Coverage ☐ No Coverage ☐ I do not know

-FOR OHIO AND INDIANA RESIDENTS ONLY-

Medical Payment Insurance (MedPay) Information

To the best of your (the patient and/or patients guardians) knowledge, do you, or the owner of any vehicle in which you were a passenger on the accident date, have Medical Payments Insurance (MedPay) coverage?

☐ Yes ☐ No ☐ I do not know If yes, what is the amount of coverage? $ _____

ASSIGNMENT OF INSURANCE BENEFITS & RELEASE OF INFORMATION

The undersigned patient/insured, _____ **(print name of patient/insured or parent/ guardian if patient is a minor)**, knowingly, voluntarily and intentionally assigns the benefits of insurance or Medical Payments policy of insurance or the responsible insurer to the above described Medical Provider for any and all services rendered to the undersigned patient/insured. It is the intent of this Medical Provider to accept this assignment of benefits. The undersigned patient/insured directs the insurer to pay the Medical Provider directly (i.e. payments to be mailed and made payable to the medical provider only and not to me- however, if any payment is sent to me, I hereby agree to immediately forward or endorse such payments directly to the Medical Provider) for the services rendered. The insurer is further directed by the Medical Provider and the patient to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured from liability unless there has been a prior written settlement agreed to by the Medical Provider and the insurer as to the amount payable under the insurance policy or contract. The Medical Provider hereby objects to any reductions or partial payments made at the discretion of the insurer. Any partial or reduced payment issued by the insurer and deposited by the Medical Provider shall be done so under protest and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the Medical Provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this Medical Provider reserves the right to seek the full amount of the bills submitted. In the event the subject medical benefits are disputed for any reason, including but not limited to, medical reasonableness and/or necessity, the undersigned patient/insured hereby instructs the insurer to set aside any amount disputed and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. Any partial payment, regardless of the accompanying language, will be deemed a partial payment and the insurer will be making the payment at its own risk unless there is a prior written settlement agreed to by this provider. I hereby instruct the insurer to notify the above provider immediately of any dispute.

The undersigned patient/insured hereby agrees to pay any deductible or co-payments for services rendered after the policy of insurance exhausts. The undersigned understands this assignment will remain in full force and effect and will NOT be revoked unless the revocation is agreed to by both the Medical Provider AND the undersigned patient or the patient's attorney/representative. This assignment applies to both past and future medical expenditures. A photocopy of this assignment is to be considered as valid as an original.

Release of information: I hereby authorize this medical provider or their representative to furnish my insurance company or companies and my attorney, as listed on the patient information form, with any and all information, that may be contained in my medical records and obtain any insurance coverage information in my file. I also hereby authorize this medical provider to obtain copies of my medical records, including but not limited to, documents, reports, scans, notes, opinions, x-rays, and MRIs, from any other medical provider or any insurance company.

Please read before signing. If you do not completely understand this document, please ask us to explain it to you. If you sign below, we will assume you understand and agree to the terms. If you have an attorney, please ask them to review and explain anything you do not understand.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information may be guilty of a felony of the third degree.

Patient's Signature: (If patient is a minor, signature of parent/guardian) Date:

_____ _____

APPLICATION FOR "NO FAULT" BENEFITS (1 OF 2)

THIS FORM ONLY APPLIES TO RESIDENTS OF THE FOLLOWING STATES- FLA, MI, NJ, NY, PA, HI, KY, MA, MN, ND and UT

Name of Insurance Company _____ Date _____

Our Policy Holder _____ Date of Accident _____ File # _____

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY. MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING IN- FORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Complete Address: _____

Permanent Address, if different: _____

Date of Birth _____ Social Security No. _____ How long have you lived in your State? _____

Date and Time of Accident: _____ Place of Accident (Street, City, ST) _____

Brief description of accident and vehicles involved:

☐ Rear end ☐ Side Impact ☐ Head on ☐ Slip and Fall

What type of car were you in at time of accident _____

As a result of this accident, were you injured? ☐ Yes ☐ No If Yes, complete the rest of this form. If no, sign below.

SIGNATURE _____ **DATE** _____

Describe your injury below

_____

_____

_____

_____

_____

Were you treated by a doctor? ☐ Yes ☐ No

Doctor's name and address: _____

If you were treated in a hospital, were you: ☐ In-patient ☐ Outpatient

Hospital Name and Address _____

Will you have more medical expenses? ☐ Yes ☐ No At the time of the accident, were you in the course of your employment? ☐ Yes ☐ No

APPLICATION FOR "NO FAULT" BENEFITS (2 OF 2)

List names and addresses of your present employer(s) and give your occupation and dates of employment.

EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO

As a result of your injury have you had any other expenses? ☐ Yes ☐ No If Yes, explain below.

TO BE ELIGIBLE FOR BENEFITS, COMPLETE AND SIGN THIS APPLICATION, SIGN AND ATTACH AUTHORIZATION(S) and RETURN PROMPTLY WITH ANY MEDICAL BILLS RECEIVED TO DATE.

Patient's Signature **Date**

INTAKE QUESTIONNAIRE

Details of present incident (Submit to your attorney for completion, if you have representation)

Patient's Name: _____ Date of Accident: _____ Today's Date: _____

Contact Phone #s: _____ Attorney Name: _____

Were you the: ☐ Drive ☐ Front Seat Passenger ☐ Back Seat ☐ Passenger ☐ Pedestrian ☐ On the job ☐ Other

Do you own a vehicle of your own? ☐ Yes ☐ No

If yes, name of auto insurance: _____

If no, do you live with a blood relative that owns a vehicle? ☐ Yes ☐ No

If yes, name of auto insurance: _____

If no, name of auto insurance of vehicle you were in at time of accident: _____

From what State is your Auto Insurance Policy? _____

Policy# _____ Claim#: _____

Relation to Insured(check one): ☐ Self ☐ Spouse ☐ Child ☐ Other _____

If not the insured, name of insured: _____ Relationship to policyholder: _____

Description of the vehicle you were in? Make: _____ Model: _____ Year: _____

Was your vehicle stopped at the time of the accident? ☐ Yes ☐ No

Was your vehicle moving right before the moment of impact? ☐ Yes ☐ No Estimated speed: _____MPH

Seatbelt: ☐ Worn ☐ Not Worn ☐ Don't know Air Bag Deployed: ☐ Yes ☐ No ☐ Car does not have airbags

Aware of Crash: ☐ Aware ☐ Surprised Did you brace yourself? ☐ Yes ☐ No If yes, with ☐ arms ☐ legs ☐ both

After Incident

Unconscious? ☐ Yes ☐ No If yes, unconscious for _____ (unit of time)

After the accident, I had pain in the following areas:

☐ Head ☐ Neck ☐ Mid Back ☐ Low Back ☐ RT Shoulder ☐ LT Shoulder ☐ RT Elbow

☐ LT Elbow ☐ RT Wrist ☐ LT Wrist ☐ Fingers ☐ LT Foot ☐ RT Hip ☐ LT Hip

☐ RT Knee ☐ LT Knee ☐ RT Ankle ☐ LT Ankle ☐ RT Foot

Symptoms first appeared: ☐ Immediately _____(min/hrs) after the accident ☐ Next Day _____ (min/hrs) after

Did you receive paramedic attention? ☐ Yes ☐ No

Did a law enforcement officer investigate the scene of the accident? ☐ Yes ☐ No

Was anyone citied for being at fault or ticketed: _____

After the accident, I went: ☐ Home ☐ Work ☐ Hospital ☐ Family Physician ☐ Other _____

If you went to the hospital or a medical center:

Name of Hospital/Medical Center _____

How did you get there? ☐ Ambulance ☐ Relative ☐ Friend ☐ Other _____

Did you sustain any broken bones? ☐ Yes ☐ No If yes, which one(s): _____

Did you have imaging done due to accident? ☐ Yes ☐ No If yes, which: ☐ CT scan ☐ MRI ☐ X-rays

What body parts? _____

Were you prescribed: ☐ Pain pills ☐ Muscle Relaxers ☐ N SAIDS (Anti-inflammatory) ☐ Other _____

The information provided above is true and correct to the best of my knowledge.

Patient's Signature: _____

Interviewer Signature: _____

VERIFICATION OF NON-OWNERSHIP

Only complete if you DO NOT own a vehicle.

Patient Name _____

Date of Birth _____

I confirm the following:

1. That I was involved in an automobile accident on _____
2. That I did not own an operable motor vehicle on the date of the accident.
3. That I did not live with any relative who owned an operable motor vehicle on the date of the accident.

Patient's Signature _____

Date _____

Witness Signature _____

Date _____

PATIENT FRAUD/SOLICITATION DISCLOSURE

Name of Patient:

Insurance Fraud at any BEST Location will not be tolerated. It is a crime in for any person to offer to pay, and any patient to receive a commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind to induce a patient to be referred to or receive treatment at a health care facility.

It is also a Felony and insurance fraud for a patient to present any statements pertaining to treatment that will result in a claim for insurance benefits that contain false, incomplete, misleading information or documents.

In consideration of and as an express condition to the Medical Provider agreeing to treat to you- I, the undersigned patient, under the penalty of perjury, hereby acknowledge the following to be true and correct:

1. That I am seeking treatment as a direct result of injuries that I have sustained.
2. That I have not been offered or otherwise promised a commission, bonus, rebate, kickback, or bribe, cash or payment of any kind, directly or indirectly, from anyone as an inducement to seek treatment at BEST. In addition, I have not received any promises at this location that applicable deductibles and co-payments that I may be financially responsible for will be waived in the future as an inducement to receive treatment.
3. That all statements concerning my involvement in a motor vehicle accident, the injures that I have sustained, and any supporting documentation that I have provided in connection with the treatment that I am seeking are true and correct to the best of my knowledge and belief.

Patient's Signature

Date

Witness Signature

Date