PI MEDPAY FORM

[ ] Do I have Medpay? ____

[ ] How much Medpay do I have?____________________________________

[ ] Do I have primary or excess Medpay? ______________________________

[ ] Adjuster name and phone number ________________________________

[ ] Claim # ____

PERSONAL INJURY QUESTIONNAIRE

Name: ______________________________ Today's Date: ______________

Date of Accident: ______________________________ Time of Day: ______________

Were you the: Driver Front Seat Passenger Back Seat Passenger
Number of people in your vehicle: __________
Your vehicle was: Stopped Moving Starting Slowing Down

Name of street that you were on: ______________________________
Make, Model and Year of your vehicle: ______________________________
Make, Model and Year of the other vehicle: ______________________________
The force of impact was: Mild Moderate Severe
Were you struck from: Behind Front Left Right
Approximate speed of your car: ________ mph

Was your car drivable after the accident? Yes No
Were you wearing both a lap and shoulder belt? Yes No
Did your seat have a headrest or high-backed seat? Yes No
Did you strike any part of your body against the car? Yes No
If yes, please describe: ______________________________

____

Did you lose consciousness? Yes No If so, for how long? ______________
Were the police notified? Yes No If yes, did you get a copy of the police report? ________

In your own words, describe the accident: ______________________________

____

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Did you have any physical complaints BEFORE THE ACCIDENT? Yes No
If yes, please describe in detail: ______________________________

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Immediately after the accident, did you experience any of the following:

Dazed	Shocked	Vomiting	Dizziness	Lightheadedness
Nausea	Headache	Numbness	Pain	Blurred Vision

If you had pain immediately, please describe where: ______________________________

____

____

Did you experience pain: Hours Later The Next Day Days Later
If so, where? ______________________________

____

____

After the accident, did you experience any of the following:
Bleeding: ________ If so, where: ____________________
Bruising: ________ If so, where: ____________________
Swelling: ________ If so, where: ____________________

Is your pain worse with coughing, sneezing, or straining? Yes No
If yes, please describe where it hurts: ____________________
____
____

Where were you taken after the accident? ____________________
Has another doctor treated or examined you since the accident? Yes No
If yes, please list doctor's name address and phone number: ____________________
____

Have you had x-rays for your injuries? Yes No
Was an MRI performed? Yes No If so, of what area? ____________________
Did you receive physiotherapy? Yes No If so, did it help? Yes No
Did you receive medication? Yes No If so, what kind? ____________________
Did it help? Yes No Some

Have you had any new injuries or accidents since the above injury? Yes No
Are you presently doing the same work as before the injury? Yes No
Do you have any disabilities due to the injury? Yes No
Have you lost any time from work s a result of the accident? Yes No
If yes, please state the last date worked: ____________________
Type of employment: ____________________
Are you being compensated for time lost from work? Yes No
If yes, please state the type of compensation you are receiving: ____________________

Circle the symptoms you have noticed since the accident:

Neck Pain Neck Stiffness Upper Back Pain Lower Back Pain

Pain Across the Shoulders Pain Between the Shoulders Mid Back Pain

Shortness of Breath Head Feels Heavy Headache Ringing in the Ears

Blurred Vision Difficulty Swallowing Light Bothering Eyes Lightheadedness

Dizziness Depression Fatigue Insomnia Irritability Nervousness

Cold Sweats Poor Concentration Loss of Memory Loss of Smell

Loss of Taste Cold Hands Pins & Needles in Hands/Arms Pain Down Arm

Numb Fingers Numbness in Hands/Arms Weakness in Grip/Hands/Arms

Pain in Hands Pain Down Legs Cold Feet Leg Cramps

Numbness in Legs/Feet Diarrhea Constipation Jaw Pain

Have your symptoms caused any difficulty with:

Work	Yes	No
Sleep	Yes	No
Exercise	Yes	No
Home Life	Yes	No
Driving	Yes	No

I have pain in my: ______________________________

It began: Immediately Hours Later Days Later

The pain is: Getting Better Staying the Same Getting Worse

I would rate this condition: (No Pain) 0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10(Severe Pain)

I feel the pain: 75-100% 50-75% 25-50% less than 25% of the day

The pain feels: Dull Sharp Aching Burning Stabbing

The pain gets better with: ______________________________

The pain gets worse with: ______________________________

I have pain in my: ______________________________

It began: Immediately Hours Later Days Later

The pain is: Getting Better Staying the Same Getting Worse

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The pain gets better with: ____________________
The pain gets worse with: ____________________

PERSONAL INJURY FINANCIAL AGREEMENT

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available for your condition. To familiarize you with the financial policy of our office, we would like to explain to how your medical bills will be handled.

Party Responsibility

If you were involved in an auto accident in your own vehicle, we will file a claim with the medical payment portion of your own automobile insurance policy, or your private health insurance policy to cover the treatment charges incurred in our office.

If you were a passenger in another vehicle, the insurance company, which insures the automobile may be billed directly for your medical services, incurred.

If another vehicle has caused the accident, we will first submit a claim to your automobile medical policy or private health insurance policy for payment PRIOR to submitting claim to the insurance carrier of the party claimed to be at fault (California Insurance Code, Section 491 prohibits your insurance carrier form increasing your premiums for being involved in an accident in which you were not at fault).

Attorney Liens

If you hire an attorney to represent you in a lawsuit, we will accept a signed Doctor's Lien agreement guaranteeing direct payment to our office for any unpaid balance upon the settlement of your case. It is our policy, however, to submit a claim to your auto or health insurance policy for immediate payment PRIOR to waiting for payment of any balance owing at the time settlement of your case. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

Responsibility for payment

As a courtesy to you, we will gladly submit your charges to your automobile or health insurance company, and to your attorney, if applicable, however, all services rendered to you are your personal responsibility regardless of any insurance reimbursement or settlement you may or may not receive. If you have any applicable insurance coverage to pay for your services then, it is our policy that you personally pay all charges at the time of service.

Once again, we'd like to welcome you to our office. If, at any time, you have any questions about your care, please don't hesitate to ask.

I have read and agree to the above.

____
Date

______________________ ______________________
Print Name Patient's Signature

NOTICE OF DOCTOR'S LIEN

ATTORNEY: ________________________________
PATIENT: __________________________________
DATE OF INJURY: ____________________________

I hereby authorize Beverly Hills Comprehensive Medical Group (BHCMG) to furnish you, my attorney, with a full report of my examination findings, diagnosis, treatment, etc., in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay BHCMG such sums as may be due and owing them for all services rendered to me by reason of this accident and to withhold such from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate BHCMG. I hereby allow a lien to the same, against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated for injuries in connection therewith.

I fully understand that I am directly and fully responsible to BHCMG for all medical bills submitted to them for services rendered me, and that this agreement is made solely for the protection and in consideration of their office awaiting payment for any unpaid balance owing services rendered to me. **I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover.**

I agree to promptly notify BHCMG of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and promptly deliver a copy this lien to any such substituted or added attorney(s).

Please acknowledge your agreement to this request by signing below and returning it to BHCMG within 5 days of receipt. I have been advised that if you do not wish to cooperate in signing and returning this lien, BHCMG will not await payment but may declare the entire balance immediately due and payable by me.

______________________________ ______________________________

DATE PATIENT'S SIGNATURE

____

PATIENT'S NAME (PRINT)

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above, and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate BHCMG. Attorney further agrees to issue this payment to the BHCMG office immediately upon settlement. In the event this lien is litigated, the attorney agrees that the prevailing party will be awarded attorney fees and costs.

______________________________ ______________________________

DATE ATTORNEY'S SIGNATURE

____

ATTORNEY'S NAME (PRINT)