impactMD Accident Care

MOTOR VEHICLE ACCIDENT ASSESSMENT FORM

Your name:_____ Today's date:_____

Location of accident: _____ Date of accident:_____

Where were you sitting?

☐ Driver seat ☐ Front Right

☐ Rear Left ☐ Rear Right

Where was your car hit?

☐ Rear-end ☐ Front-end

☐ T-Bone ☐ Other_____

On which side was your car hit?

☐ Left-side ☐ Right-side

☐ Other_____

Did you go to the emergency room? ☐ Yes ☐ No

Have any X-rays/CT scans/MRIs been taken? ☐ Yes ☐ No

Did the airbag deploy? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No

Was there a police report filed and who was at fault?_____

What symptoms did you have after the accident/injury?_____

What was your treatment **on the day** of the accident/injury?_____

What has been your treatment **since** the accident/injury?_____

Which doctors have you seen regarding this accident/injury?_____

What symptoms you are experiencing now? (Start with the worst complaint) _____

_____

_____

Have your symptoms gotten better or worse since the accident/injury?_____

Did any of your present symptoms exist before the accident? ☐ Yes ☐ No (please describe)_____

_____

If Yes, how or are the symptoms different?_____

Do you think that these symptoms are directly related to the accident/injury?_____

Have you received other treatments for these same areas in the past? ☐ Yes ☐ No

If so, what were the treatments?_____

_____

Automobile Insurance/Attorney Information

Please provide us with information about automobile insurance coverage (yours and the party that injured you) and attorney.
Please provide the staff with a copy of your automobile insurance card if you are using this insurance.
NOTE: IF YOU DO NOT CURRENTLY HAVE AN ATTORNEY AND LATER ACQUIRE ONE, YOU MUST NOTIFY OUR OFFICE.

Have you hired an attorney for this case? ☐ Yes ☐ No

If yes, please provide attorney name _____ attorney phone _____

My case is: ☐ currently in litigation ☐ closed and no longer in litigation ☐ Other _____

I have a copy of the police report concerning this accident: ☐ Yes ☐ No

Med Pay/UM Information (your auto insurance coverage) Insured: _____

Insurance Co: _____

Mailing address: _____

_____

Agent: _____

Agent tel. #: _____

Policy #: _____

Med pay $ amount: _____

Claim # _____

Liability Information (at fault party's coverage)

Name of party at fault: _____

Policy holder: _____

Insurance Co: _____

Mailing address: _____

_____

Policy #: _____

Adjuster's name: _____

Adjuster Tel. #: _____

Have you filed a claim? ☐ Yes ☐ No

Claim #: _____

Form reviewed by:

_____
Signature of practitioner and date

Received and logged by billing department:

_____ _____
Date Signature of biller

MOTOR VEHICLE ACCIDENT/ PERSONAL INJURY
INSURANCE ELECTION FORM

OPTION 1 – PERSONAL MEDICAL INSURANCE

I understand I could use my personal health insurance for my medical treatment. I understand I will be responsible for all co-pays and deductibles at the time of service that are associated with this insurance. I understand that all co-pays must be paid at the time of service based on the contractual agreement between my doctor and my health insurance carrier.

OPTION 2 – THIRD-PARTY LIABILITY INSURANCE AND/OR MY PERSONAL UM/MED-PAY INSURANCE

I understand I could instruct my doctor to bill the third-party liability insurance and any uninsured/ underinsured or med pay insurance, applicable to my accident. I understand I will not be required to pay any copays or deductibles under this option. I am instructing my doctor to not bill my personal medical insurance and rather bill any applicable third-party liability insurance and/or UM/Med-Pay insurance.

I understand that this is a third-party liability claim (auto claim) and all expenses will be billed to the third-party insurance involved. I understand that Blick MVA Collections LLC dba ImpactMD Accident Care will hold my bills until I am released from their care. A Physician's Lien will then be filed and mailed via USPS Certified Mail to me. I also understand that payment is due when the case settles with the insurance carrier involved and that I am financially responsible for ALL charges, subject to state and federal laws regarding balance billing, whether or not paid by any insurance company and/or attorney.

In consideration of being treated without requiring payment until settlement of my insurance claim, I also hereby authorize Blick MVA Collections LLC dba ImpactMD Accident Care to endorse my name to any draft or check received by the above medical providers to be used for payment on my account.

I am instructing my doctor to proceed with:

☐ OPTION 1 – USE MY PERSONAL MEDICAL INSURANCE

☐ OPTION 2 – USE THIRD-PARTY LIABILITY INSURANCE AND/OR UM/MED-PAY INSURANCE

_____	_____	_____
Print Name	**Patient Signature**	**Date**

impactMD Accident Care

Medical History

Conditions:

- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Bowel Disorder
- ☐ Cardiac Disease/Disorder
- ☐ Cirrhosis
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes, Type I
- ☐ Diabetes, Type II
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gastric Ulcer
- ☐ Gout
- ☐ Heart Attack
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hypertension
- ☐ Kidney Failure
- ☐ Lupus
- ☐ Migraines
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Other:_____

Allergies:

_____

_____

Medications: *List ALL medications, strength, and quantity that you are currently taking:*

_____

_____

_____

_____

_____

_____

Surgical History:

_____

_____

_____

_____

_____

Review of Systems:

Cardiovascular

- ☐ Irregular heartbeats
- ☐ Palpitations

Gastrointestinal

- ☐ Change in bowel habits

Neurologic

- ☐ Balance difficulty
- ☐ Difficulty speaking
- ☐ Dizziness
- ☐ Fainting
- ☐ Paralysis
- ☐ Seizures

Musculoskeletal

- ☐ Joint stiffness
- ☐ Leg cramps
- ☐ Pain in shoulder(s)
- ☐ Sciatica
- ☐ Swollen joints
- ☐ Trauma to ankle(s)
- ☐ Trauma to arm(s)
- ☐ Trauma to hip(s)
- ☐ Trauma to knee(s)
- ☐ Weakness

Psychiatric

- ☐ Anxiety
- ☐ Depressed mood
- ☐ Difficulty sleeping
- ☐ Suicidal thoughts

Genitourinary

- ☐ Blood in urine
- ☐ Difficulty urinating

Women ONLY

- ☐ Breast lump
- ☐ Heavy bleeding during menses
- ☐ Painful intercourse

NOTICE OF PRIVACY PRACTICES IN REGARD TO HIPAA AND MEDICAL COLLECTIONS

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. If you have any questions, don't hesitate to contact us at 405.483.3075.

It is the policy of Blick MVA Collections LLC DBA ImpactMD Accident Care, Comprehensive Spine and Pain, and Western Oklahoma Pain Specialists (collectively, "the Physician") to keep all of your medical and personal information confidential. We will only use or disclose your information for the following reasons:

Treatment: We will share your medical information with other medical providers who are involved in your care (including hospitals and clinics), to refer you for treatment, and to coordinate your care with others.

Payment and/or authorization of a procedure: We may use and disclose protected health information (PHI) when it is needed to receive payment for services provided to you. For example, if your insurance requires certain dictations or office notes to determine if a procedure is deemed necessary.

Health care operations: We will use and disclose PHI when it is needed to make sure we are providing you with good service. For instance, we may review your records in order to make certain quality services were given.

The Physician may contact you to provide appointment reminders.

Other uses or disclosures of your PHI that may occur include:

- If you have given us permission in writing to release part or all of your information.
- When ordered to do so by a valid court order.
- When business associates of the physician sign agreement to protect your privacy.
- When required by state law. For instance, when reporting injuries and disease as required by the Public Health Codes or to prevent the spread of disease such as tuberculosis (TB).
- We can share your information with anyone as necessary; consistent with Oklahoma Law and the Oklahoma State Department of Health's policies and procedures, if we feel there is imminent danger. For example, we will release the minimum information necessary if we believe it will prevent or lessen a serious and imminent threat to the health and safety of a person or the public.

Emergency Coordination: We will share your medical information with other medical providers who are involved in your care to coordinate your care with others (such as emergency relief workers or others who can help in finding you appropriate health services).

Any Other Use or Disclosure of Your PHI Requires Your Written Authorization:

Under any circumstance other than those listed above, the Physician will ask for your written authorization before we use or disclose your PHI. Specifically, the Physician must obtain your written authorization for the use and disclosure of psychotherapy notes, marketing, and the sale of PHI. The Physician will not sell PHI without your written authorization. You can later cancel your authorization in writing and we will not disclose your PHI after we receive your cancellation, except for disclosure which we process before we received your cancellation.

Your Rights:

You have the right to:

- Receive of persons or organizations, other than those listed above, to whom we release your information
- Request limits on how your information is used or disclosed; however, we are not required to agree to those limits unless you pay out of pocket in full for a service. If you pay out of pocket in full for a service and you request we not share information for that service with your insurance company we will honor your request.
- Ask that we not contact you at home.
- Inspect and copy your medical records except in the cases involving certain psychotherapy notes.
- Amend incorrect information in your medical record.
- Revoke your written permission for release of information.
- Receive notification if your unsecured health information is breached.
- Receive a paper copy of this privacy notice.

Our responsibilities:
Federal law requires that the Physician and its entities and affiliates to:

- Maintain the confidentiality of your protected health information.
- Provide you with a copy of this notice.
- Abide by the terms of this notice.
- Only change this notice as permitted by federal rules.
- Provide you with a way to file complaints regarding privacy issues.

HIPAA Signature Page

Acknowledgment of Receipt of “Notice of Privacy Practices”

I acknowledge that ImpactMD Accident Care, Comprehensive Spine and Pain, and/or Western Oklahoma Pain Specialists have given me a copy of a Privacy notice either by web, email, US Mail, or in person by the federal government’s HIPAA legislation. I have been provided the opportunity to discuss concerns I may have regarding the privacy of my health:

Date:_____ **Name of Patient:**_____

The government mandated that as of April 14,2003, all health care patients are to receive from their clinicians a notice (hereafter referred to as “Notice”) regarding the protection of their private health care information in compliance with the health insurance Portability and Accountability Act (“HIPAA”) Privacy Rule (45 C.F.R. parts 150 and 154).

This form documents that your physician has given you the “Notice” that is required. HIPAA covers what is called “protected health information” (PHI) that is used for treatment, payment and health care operations. PHI is information in your health record that could identify you.

The Notice contains basic information about:

1. How your PHI may be used and disclosed for treatment, payment and healthcare operations (these terms are defined in the notice).
2. Which uses and disclosures require authorization from you and which do no.
3. How you may revoke an authorization you have made.
4. Certain rights you have to restrict use and disclosure of PHI, to receive confidential communications by alternative means and at alternative locations, to inspect and copy your records, to amend your records or to have an accounting of disclosures.
5. A list of my duties to protect the privacy of PHI, my right to change the privacy policies and practice described in the Notice, and how I will inform you of changes.
6. What you can do if you have any complaints about violations of your privacy rights, about decisions regarding access to your records I may make.
7. Any restrictions, any limitations you or I wish to put on the use and disclosure of your PHI.

Generally, this Notice is given to a patient in person, by email, or downloaded from the web. A copy of the Notice is available by request.

This page documents that you have received a copy of the Notice.

Signature:_____ **Date:**_____

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information. This form is for use when authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____**Date of Birth:** _____

I. My Authorization

I authorize Blick MVA Collections LLC dba ImpactMD Accident Care, its agents, employees, and affiliates to use or disclose the following health information.

☐ All of my health information
☐ My health information for the following condition(s):_____
☐ I do not authorize disclosure of my health information

ImpactMD Accident Care may disclose this health information to the following recipient(s), please include medical providers, family, and friends:
Name, relationship and/or organization _____

I also hereby authorize the staff of ImpactMD Accident Care (the "Physician") to furnish my attorney, other medical providers within my care, liability insurance company, or health insurance carrier, a full report of all medical records and charges concerning my evaluation and treatment regarding my accident or potential legal action.

II. My Rights

- I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made. I may not be able to revoke this authorization if its purpose was to obtain insurance.
- I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.
- I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Signature of Patient: _____ Date: _____

If the patient is a minor or unable to sign please complete the following:

☐ Patient is a minor: _____ years of age
☐ Patient is unable to sign because: _____

DISCLAIMER: If you are signing this authorization electronically, you agree that your electronic signature is the legal equivalent of your physical signature on this document.

Signature of Authorized Representative: _____ Date: _____

III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases (including, but not limited to Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS)), abortion, or mental health treatment**. Separate consent must be given before this information can be released.

☐ I consent to have the above information released.
☐ I do not consent to have the above information released.

DISCLAIMER: If you are signing this authorization electronically, you agree that your electronic signature is the legal equivalent of your physical signature on this document.

Signature of Patient or Authorized Representative: _____ Date: _____