Belleview Chiropractic Payment Policy:
Who Pays for Your Care?

Dear Patient:

We know auto accidents are stressful and painful. Our doctor has 15+ years of successfully treating auto injuries. Dealing with auto insurance companies is confusing and frustrating. We hope this answers questions regarding payment of services received that you might have.

Who pays for my care if the accident **is** my fault?

Under Colorado law, medical payment coverage (med pay), under your auto insurance policy, is the **primary billing party and will be billed first**. If you have waived your rights to medical payment coverage on your auto insurance policy or choose to forgo medical payment coverage usage, you are now considered the primary source of payment and you **must provide payment at the time services are rendered.** If **medical payment coverage is exhausted you are now responsible for payment**. Most, not all **health insurance companies will deny coverage** for auto-accidents much like they will not pay for an accident that occurs at work.

Who pays for my care if the accident **is not** my fault?

Under Colorado law, the presumed, at-fault driver's insurance company is **never obligated to pay for medical treatment for you at any time**, much less as and when it is obtained, or for any other expenses until and unless it chooses to or its insured has been legally determined to be at fault. Even then, its **duty is only to its insured, never you**. The treatment bills will be taken into consideration if a settlement is being negotiated but, again, the other drivers insurance company never has to pay for the care you have received. So, when making decisions about whether to continue care, please make sure to **consider your own sources of payment**. If you have **medical payment coverage (med pay)** under your auto policy, that insurance is primary and will be billed first. It is **illegal in the state of Colorado to raise auto policy rates based on medical payment coverage usage**. If you are **legally deemed not at-fault** a third party lien for secondary payment will be considered for continuation of care, only after your medical payment coverage is exhausted, and **payment must be rendered upon settlement**. However, should payment not be received within 6 months after termination of care, or should you terminate care before being dismissed by the physician**, you will be charged the amount outstanding on your account to a designated credit card.**

By signing this you are stating that you have fully read and understood Belleview Chiropractic's payment policy and agree to abide by the aforementioned policy.

____
Printed Name

______________________________ Date______________
Signature

CONFIDENTIAL AUTO ACCIDENT INFORMATION

(PLEASE PRINT) Date:____________

Last name First name MI Sex( )M ( )F

Address City State Zip Code

Home phone Work phone Cell phone

Social Security Date of Birth Email Address

Person to contact in case of an emergency Home phone Work phone

INSURANCE INFORMATION

Please provide the staff with any and all information to be copied:
Claim Numbers and Adjusters Information, Vehicle Policy Information, Police Reports and Health Insurance Information.

Date of auto accident:__________________________Time_______________________AM/PM

List all those in the vehicle with you:

Name Relationship Age Injured

1.____ Yes( ) No( )

2.____ Yes( ) No( )

3.____ Yes( ) No( )

4.____ Yes( ) No( )

Location of the accident:____

What were the road and weather conditions like?______________________________________

Total number of vehicles involved in accident: ( )1 ( )2 ( )3

The impact to your vehicle occurred from the: ( )Front ( ) Rear ( )Left Side ( ) Right Side

( )Other____

Total number of impacts to your vehicle: ( )1 ( )2 ( )3 ( )4 ( )Other____________________

Estimated speed of your vehicle at the time of impact: ____________mph ( ) Stopped

Estimated speed of other vehicle at the time of impact: ___________mph ( ) Stopped

Did you anticipate the impact? ( )Yes ( )No

What was the position of your head just before the impact?______________________________

Were you wearing a: ( ) Lap belt ( ) Lap and shoulder belt ( ) Neither

Was there a headrest? ( ) Yes ( ) No Did any windows break in your vehicle? ( ) Yes ( ) No

If yes describe: ____

Make and model of your vehicle: ____________________________________ Year___________

Please describe, in detail, how the accident happened: ___________________________________

____

____

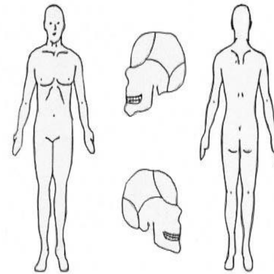
____

Please diagram the accident below:

As best as you can recall, did you strike anything inside the vehicle? ( ) Yes ( ) No
If yes, please indicate the probable item struck on the list below and then draw a line to the region of the body struck using the diagram on the right.

( ) Dashboard
( ) Steering wheel
( ) Inner door panel
( ) Windshield
( ) Shifter

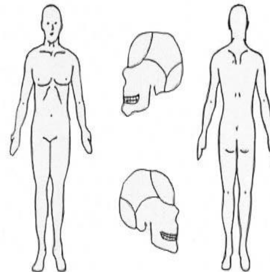
( ) Ceiling
( ) Side window
( ) Headrest
( ) Armrest
( ) Other:_______________



Did you receive: ( ) Cuts ( ) Bruises ( ) Abrasions

If yes, use the diagram below to detail where these visible injuries occurred:

Use "C" for cuts
Use "B" for bruises
Use "A" for abrasions



At the time of the accident, did you lose:

Consciousness	( ) Yes	( ) No
Bowel or Bladder control	( ) Yes	( ) No
Fluids from the ears	( ) Yes	( ) No

Did you have any other unusual experiences? ( ) Yes ( ) No

If yes, describe how you felt: ____

____

Describe any damage done to the vehicle you were driving: ______________________________

____

Were you able to get yourself out of the vehicle? ( ) Yes ( ) No

If no, describe how you were removed from the vehicle: _________________________________

____

Who was called or came to the scene? ( ) Highway Patrol ( ) Local Police
( ) Sheriff ( ) Paramedics
( ) Ambulance ( ) Other _______________

Was a report made? ( ) Yes ( ) No Do you have a copy of the report? ( ) Yes ( ) No

Were you on company business at the time of the accident? ( ) Yes ( ) No
If yes, did you report the accident to your employer? ( ) Yes ( ) No

Did you receive any first aid at the scene of the accident? ( ) Yes ( ) No

If yes, what was done and by whom? ____

____

Did you go to the emergency room? ( ) Yes ( ) No

Did you go to a Doctor's office? ( ) Yes ( ) No
If you answered "yes" to either of the 2 questions above, complete the following:

A. Who attended you there? ____

B. What was done for you there? ( ) Examination ( ) Medication ( ) Muscle Relaxants

( ) Anti-inflammatory ( ) X-Rays ( ) Supports/Braces ( ) Pain Medication ( ) Other ___________

C. What diagnosis were you given? ____

D. Were you told to do anything by the attending Doctor? ( ) Yes ( ) No

If yes, please explain: ____

Were you hospitalized as a result of the injuries you sustained from the accident? ( ) Yes ( ) No
If yes, complete the following information:

Name of Hospital/Location: Entered/Discharged Treating Doctor

____

____

What was done for you at the hospital? ____

____

Describe how you felt:

A. Immediately after the accident: ____

____

B. Later that day: ____

C. The next day: ____

____

____

Did you see any other health care professional since the day of the auto accident? ( ) Yes ( ) No

If yes, please complete the information below. Begin with the person you saw first and proceed to the most recent.

Name	Title	Dates Seen	What was performed?

What medications, prescribed or not, are you currently taking to treat symptoms of your injury?

____

____

What other medications, prescribed or not, are you currently taking for problems unrelated to your injury?

____

____

Have you missed work as a result of the auto accident? ( ) Yes ( ) No

If yes, please provide details: ____

____

____

Health History

Have you had any significant injury or illness of any type “prior” to the injury? ( ) Yes ( ) No
If yes, what was the nature of the problem and when did it occur? If professional care was rendered, how long were you treated, by whom and what was performed?

___

___

Have you ever had any surgeries? ( ) Yes ( ) No

If yes, what for and by whom and what was done: ___

___

Indicate if you have any immediate family members with any of the following:
☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus ☐ Heart Problems ☐ Cancers ☐ ALS

___

Please check all that apply:

Present	Past		Present	Past		Present	Past	
		Loss of Appetite			Kidney Stones			Diabetes
		Hepatitis			Kidney Disorder			Excessive Thirst
		Cancer			Bladder Infection			Frequent Urination
		Tumor			Painful Urination			Depression
		Asthma			Loss of Bladder Control			Systemic Lupus
		Chronic Sinusitis			Prostate Problems			Systemic Lupus
		High Blood Pressure			Abnormal Weight Gain/Loss			Dermatitis/Eczema/Ras h
		Heart Attack			Jaw Pain			HIV/AIDS
		Chest Pains			Ulcer			Ankle/Foot Pain
		Stroke			Rheumatoid Arthritis			Abdominal Pain
		Angina			General Fatigue			Arthritis
		Smoking/Tobacco Use			Muscular Incoordination			Liver/GallBladder Disorder
		Drug/Alcohol Dependency			Visual Disturbances			Allergies
					Dizziness			
						For Females Only		
								Birth Control Pills
								Hormonal Replacement
								Pregnancy
		Other(s):						

CURRENT MEDICAL COMPLAINTS

Please use the space provided below to describe any medical complaints you are currently experiencing, or any additional comments you may wish to make regarding your condition.

____

____

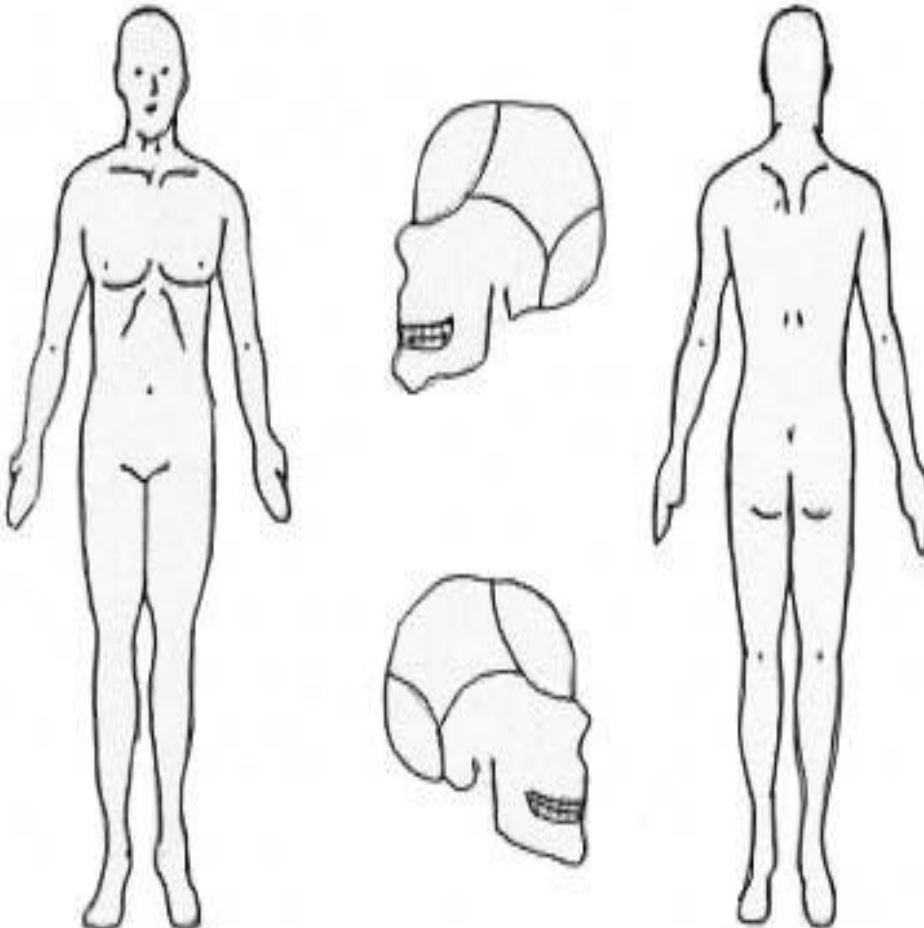
____

____

Mark the areas on the body where you feel the described sensations. Use the appropriate symbol. Include all affected areas.

Numbness = = **Pins and Needles oo** **Burning xx**

Stabbing/Sharp Pain // **Aching/Dull Pain ((**



INSTRUCTIONS: Please print your response and circle the most appropriate choice or choices.

Primary complaint	Secondary complaint	Tertiary complaint
______________________	______________________	______________________

When did the problem begin? ____

This problem began:

Gradually	Gradually	Gradually
Suddenly	Suddenly	Suddenly

This problem can best be described as:

Dull	Dull	Dull
Throbbing	Throbbing	Throbbing
Sharp	Sharp	Sharp
Stabbing	Stabbing	Stabbing
Burning	Burning	Burning
Tingling	Tingling	Tingling
Other:__________________	Other: _________________	Other: ____________

This problem is:

Constant	Constant	Constant
Near Constant	Near Constant	Near Constant
Frequent	Frequent	Frequent
Rarely Present	Rarely Present	Rarely Present
Other:_________________	Other: _________________	Other: _________________

This problem is worse with:

Coughing	Coughing	Coughing
Sneezing	Sneezing	Sneezing
Straining	Straining	Straining
Sleeping	Sleeping	Sleeping
Lifting	Lifting	Lifting
Rest	Rest	Rest
Activity	Activity	Activity
Weather Changes	Weather Changes	Weather Changes
Other:______________________	Other: ______________________	Other:_________________

This problem is better with:

Medication	Medication	Medication
Rest	Rest	Rest
Activity	Activity	Activity
Stretching	Stretching	Stretching
Treatment	Treatment	Treatment
Other: ______________________	Other:______________________	Other:_________________

What household, social, recreational, at work activities are now difficult or impossible to do because of your condition?

____

____

QUESTIONNAIRE FOR POSTCONCUSSION SYNDROME

Please place a check mark "☑" in the space provided next to any of the follow symptoms that you have noticed since your accident. If you are unsure, then please place a "?" in the space. If you should have any additional symptoms of an unusual nature, then please list them in the space provided at the bottom of the page. Thank you for your assistance.

_____ 1. Light headedness

_____ 2. Vertigo/dizziness

_____ 3. Neck pain an/or stiffness

_____ 4. Headache

_____ 5. Photophobia (eye sensitive to bright light)

_____ 6. Phonophobia (sensitivity to loud noises)

_____ 7. Tinnitus (ringing in the ears)

_____ 8. Impaired Memory

_____ 9. Difficulty Concentrating

_____ 10. Impaired comprehension or awareness

_____ 11. Forgetfulness

_____ 12. Impaired logical thinking

_____ 13. Difficulty with new or abstract concepts

_____ 14. Insomnia (difficulty sleeping)

_____ 15. Easy Fatigability

_____ 16. Apathy

_____ 17. Outbursts of anger

_____ 18. Mood swings

_____ 19. Depression

_____ 20. Loss of libido

_____ 21. Personality change

_____ 22. Intolerance to alcohol

Comments: ____

____

____

Insurance Billing Information

Regardless of fault, in the State of Colorado, your MedPay (part of your auto insurance policy) will cover medical expenses. If you do not have MedPay and the accident was your fault, you are responsible for all treatment charges. If you do not have MedPay and the accident was not your fault, the party (3rd party) at fault will be responsible and all medical expenses will be paid at the conclusion of treatment.

Do you have MedPay? ____ Yes ____ No **Amount of Coverage: ______________**

Your Auto Insurance Company: ____

Adjuster Name: ____

Adjuster Phone #: ____

Claim #: ____

If you auto insurance does not include MedPay:

3rd Party Insurance Company: ____

Adjuster Name: ____

Adjuster Phone #: ____

Claim #: ____

If you have an attorney:

Attorney Company Name: ____

Attorney Name: ____

Attorney Phone #: ____

CREDIT GUARANTEE
ACCIDENT INSURANCE ASSIGNMENT
PERSONAL BALANCES

INSURANCE ASSIGNMENT:

Our Accident Insurance Liability Program is designed to render you immediate care and keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your insurance carrier on your behalf and wait up to 6 months for payment. As a prerequisite, we ask that you provide a credit card to guarantee payment of your bill and that you provide us with the following:

Your complete accident insurance information
Your health insurance card

FILING PROCEDURE:

We will submit claims on your behalf to your insurance carrier.

Balances not paid within 6 months after conclusion of your care will be charged to your designated credit card below. You will be sent a payment voucher. Should settlement be reached prior to the 6 month grace period or should care be terminated for any reason prior to your physician dismissal all balances become due immediately, will be charged to your credit card and are subject to monthly interest charges.

CREDIT CARD: ____Visa ____Master Card ____Discover

CARD HOLDER
NAME:____

CARD #:________________________________EXPIRATION____________________

I agree to the above terms and authorize you to bill the charge card. I understand that should payment not be received within 6 months after termination of my care or should I terminate care before being dismissed by my physician. I will be charged the amount outstanding on my account.

Patient Name: ___________________________________ Date: ____________________
(Please Print)

Signature: ____

Attorney/Insurance Lien and Release

To: Attorney/Insurance:____

Address:____

Re: Patient:____________________________________ Date of Injury:______________

Health Care Provider: Belleview Chiropractic
Donald W. Gibson, D.C., DAAMLP
5191 S Yosemite St. Unit A
Greenwood Village, CO 80111

I do hereby authorize Donald W. Gibson, D.C. hereinafter as the health care provider, to receive payment for the examination, diagnosis, treatment and prognosis of myself in regards to the accident in which I was recently involved in.

I hereby authorize and direct you, my attorney, or insurance company to pay directly to the health care provider for services rendered me both by reason of this accident and by reason of any other bills which are due to the office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect the health care provider. I hereby further give you a lien on my case to the health care provider against any and all proceeds of my settlement, my judgment or verdict which may be paid to you, my attorney, insurance company or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney or insurance company. I hereby instruct that in the event another is substituted in this matter, the new attorney or insurance company, honor this lien as inherent to the settlement an enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to the health care provider including billing, collection and interest changes on the unpaid balance for all bills submitted by them for services rendered me and/or supplies provided to me and that this agreement is made solely for said health care provider's additional protection and in consideration of their awaiting payment. I further understand that such payment is not contingent upon any settlement, judgment, or verdict by which I may eventually recover said fees.

Please acknowledge this letter by signing below and returning to Donald W. Gibson, the health care provider, at the address above captioned. I have been advised that if my attorney does not wish to cooperate in protecting the health care provider's interest, the health care provider will not await payment, but will require me to make payments on a current basis.

Patient's Signature:_________________________________Date:_________________________

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 above and beyond attorney's fees, costs and prior liens from any settlement, judgment, or verdict, as may be necessary to adequately protect said provider above named.

Attorney's Signature:_______________________________ Date__________________________

Belleview Chiropractic

Consent for Purposes of Treatment & Healthcare Operations

In this document, "I" and "my" refer to the patient

I consent to the use or disclosure of my protected health information by Belleview Chiropractic for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that analysis, diagnosis or treatment of me by Belleview Chiropractic may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Belleview Chiropractic is not required to agree to the restrictions that I may request. However, if Belleview Chiropractic agrees to a restriction that I request, the restriction is binding on Belleview Chiropractic. I have the right to revoke this consent, in writing, at any time, except to the extent that Belleview Chiropractic has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I may obtain a copy of the Notice of Privacy Practices of Belleview Chiropractic and understand that I have a right to read the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations or Belleview Chiropractic. The Notice of Privacy Practices for Belleview Chiropractic is also in the waiting room at the 5191 S Yosemite. This Notice of Privacy Practices also describes my rights and duties of Belleview Chiropractic with respect to my protected health information.

Belleview Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Belleview Chiropractic and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment. Our office sends thank you cards for referrals, sends periodic newsletters, posts names on a referral board, and participates in other non-private contact. If you prefer not to participate in this please let Belleview Chiropractic know.

______________________________ Signature of Patient or Personal Representative

______________________________ Printed Name of Patient

______________________________ Date of Signing

______________________________ Description of Personal Representative's Authority

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stoke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injection, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about this consent, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:________________________ Signature:________________________ Date: _________

Parent or Guardian:____________________ Signature:________________________ Date: _________

Witness name: _______________________ Signature: ________________________ Date: _________