



Naperville Rehab Clinic

445 W Jackson Ave
Naperville, IL 60540
(630) 961-1888

24024 Brancaster Dr.
Naperville, IL 60564
(630) 961-1886

Patient Name: _____ Male _____ Female _____
First Last Middle Initial (check one)

Home Address: _____ Home Phone: () _____
Work Phone: () _____

City: _____ State: _____ Zip: _____

Marital Status: M _____ S _____ D _____ W _____ Cell Phone: () _____

Email: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Driver's License #: _____

How did you hear about us? _____

Primary Insurance	Phone
Address	ID#:
City/State/Zip	Group #
Insured's Name	Date Of Birth ____/____/____
Relationship to Patient	
Insured's Employer	Phone

Secondary Insurance	Phone
Address	Policy #
City/State/Zip	Group #
Insured's Name	Date Of Birth ____/____/____

Assignment of Benefits/Release Of Information:

I authorize payment of insurance benefits directly to Naperville rehab Clinic. I authorize the doctor to release any information to any parties necessary to secure the payment of benefits and request medical information from any source necessary in order to provide the proper quality of care and to secure payment for services. I agree to be financially responsible for all charges incurred at Naperville Rehab Clinic including my insurance deductible, co-payment, and services not covered by my insurance company or paid in full through any settlement or court case. Any remaining balance I will pay in full per the policies of Naperville Rehab Clinic. I consent to receive treatment by Naperville Rehab Clinic. I have also read and understand the privacy policies of Naperville Rehab Clinic and my privacy rights under those policies.

PATIENT SIGNATURE

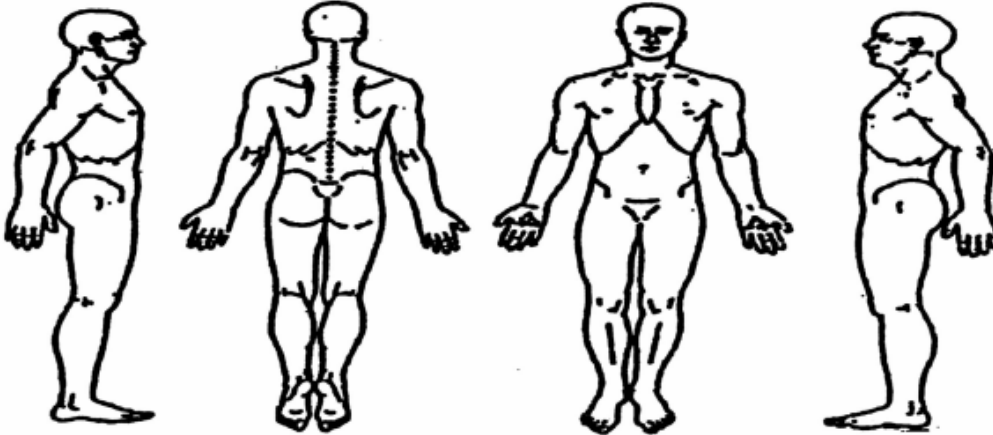
DATE

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: Auto Accident Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric like with motion
 Stiff Other: _____

5. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

10. How long have you had this problem? _____

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- Yes Yes, at times No

13. What aggravates your problem?

14. What concerns you the most about your problem; what does it prevent you from doing?

15. What is your: Height _____ Weight _____ Date of Birth _____

1. What was the date of the accident? _____
2. What time did the accident occur? _____
3. How many vehicles were involved in the accident? _____
4. What was the estimated damage to the vehicle you were in? _____
5. What state did the accident occur in? _____
6. What city did the accident occur in? _____
7. What street or intersection were you on when the accident occurred? _____
8. What direction were you traveling in? _____
9. What type of impact was the auto accident? _____
10. Did your vehicle hit anything after the accident? if yes, please describe

11. Where were you sitting in the vehicle during the accident?

12. Did you know the accident was coming? _____
13. What type of vehicle were you in? _____
14. What type of vehicle impacted yours? _____
15. At the time of the impact, how fast was your vehicle moving? _____
16. At the time of impact, how fast was the other vehicle moving? _____
17. During and after the crash what happened to your vehicle? (circle all that apply)

- kept going straight	- spun around
- kept going straight hitting a car in front	- spun around and hit a stationary object
- was hit by another vehicle	- hit a stationary object
18. Did you lose consciousness during the accident? -yes - no
19. How was your head positioned during the accident? _____
20. How was your torso positioned during the accident? _____
21. How were your hands positioned during the accident? _____
22. Did your head hit anything during the accident? -no - yes, please describe _____
23. Did your face hit anything during the accident? -no - yes, please describe _____
24. Did your shoulders hit anything during the accident? -no - yes, please describe _____
25. Did your neck hit anything during the accident? -no - yes, please describe _____
26. Did your chest hit anything during the accident? -no - yes, please describe _____
27. Did your hips hit anything during the accident? -no - yes, please describe _____

28. Did your knees hit anything during the accident? -no - yes, please describe _____

29. Did your feet hit anything during the accident? -no - yes, please describe _____

30. What kind of headrest was in your vehicle?

- movable fixed headrest
- nonmovable fixed headrest
- no headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? - yes -no

33. Did you slide out of your seatbelt during the accident? _____

34. What was damaged in your vehicle? (Circle all that apply)

- windshield
- steering wheel
- dashboard
- seat frame
- side window
- rear window
- rear bumper
- front bumper
- trunk
- front left door
- front right door
- back left door
- mirror
- knee bolster
- back right door
- completely totalled

35. Choose the items that dented inward

- floorboards
- side door
- dashboard

36. Choose the doors that would not open as a result of the accident

- front left
- front right
- rear left
- rear right

37. Did you go to the hospital? If no, why and do not answer 38-43

38. How did get to the hospital? _____

39. What was the name of the hospital? _____

40. Were you hospitalized over night? _____

41. Circle what you were prescribed at the hospital

- pain medication
- muscle relaxors
- neck brace

42. Did you recieve any stitches for any cuts at the hospital? _____

43. Were x rays taken at the hosiptal? If yes, which area was taken?

Third Party Financial Liability

Naperville Rehabilitation and Pain Management Center PC does not accept and treat based solely on 3rd party reimbursement. However, at this time we have made a “conditional” special exception for the treatment that will be rendered to _____ for injuries sustained in the date of accident_____.

Naperville Rehabilitation and Pain Management Center PC has agreed to send the bills and notes to the 3rd party insurance carrier in this case as there isn't any medpay available or health insurance that could potentially pay the charges. Naperville Rehabilitation and Pain Management Center , PC. Is agreeing to do so based solely on the condition that this case settles within 60 days from the last date of treatment and the balance is paid off at that time. Should you not settle this case within 60 days after completion of treatment, you are agreeing to make “good faith” payments of no less than \$100 per month towards the balance.

By signing below, _____, is acknowledging that he/she has read the above financial policy information and understands that he/she must begin “good faith” payments of no less than \$100 per month if the case does not settle with the 3rd party carrier within 60 days from the date treatment completes. The patient also acknowledges full responsibility for the complete balance and that Naperville Rehabilitation and Pain Management Center , P.C. will not wait for a prolonged settlement beyond the 60 days noted and is under no legal obligation to do so.”

(Patient Signature)

(Print Name)

(Date)

(Witness)

(Date)

NOTICE OF PHYSICIAN'S LIEN

TO:

PLEASE TAKE NOTICE that the undersigned, a duly licensed and practicing Chiropractic Physician (D.C.) in the State Of Illinois has rendered or will render services by way of treatment to _____, of _____, _____, IL. _____, for injuries sustained on ___/___/____, and for which injuries the following named party or parties is or may be liable to make compensation to said injured person on account of any claims or rights of action which said injured person may have:

NAMES OF PERSONS WHO MAY BE LIABLE AND THEIR ADDRESSES:

YOU ARE HEREBY FURTHER NOTIFIED that the undersigned claims a lien, as provided under the laws of the State Of Illinois relating to Physician's Liens, upon all claims and causes of action of said injured person for his reasonable charges for services rendered, up to the date of payment of such damages.

In the event that there is insurance coverage, it is suggested for your protection that this Notice Of Physician's Lien be forwarded promptly to the responsible insurance carrier.

Physician's Name & Address:

Naperville Rehabilitation and Pain Management Clinic
Kambiz Tony Maghsoudi, D.C.
445 W Jackson Avenue, Suite 102
Naperville, Illinois 60540

PROOF OF SERVICE

STATE OF ILLINOIS

COUNTY OF COOK

COUNTY OF DUPAGE

I, _____, being of legal age, attest to receiving, reading and understanding this lien and acknowledge that I am responsible to make sure the lien against my injury case is honored either by myself, my attorney or any applicable insurance carriers. I have received, reviewed and signed this lien on ___/___/_____.

Patient Signature

Personal Injury Financial Policy

1. If an attorney represents you:

You must provide us with their name and address prior to receiving services.

They must sign and fax a lien within 24 hours of your initial visit in our office.

You must provide us with the following three insurances:

- A. Personal Health Insurance
- B. Medical Pay Insurance (Your auto insurance)
- C. Liability Auto Insurance (Person who hit you)

2. If an attorney does not represent you:

You must sign a lien assigning payments for our services directly to us from your insurance carrier(s) prior to receiving services.

You must provide us with the following three insurances:

- A. Personal Health Insurance
- B. Medical Pay Insurance (Your auto insurance)
- C. Liability Auto Insurance (Person who hit you)

***Regardless of whether or not you have an attorney, if you do not have insurance you will be considered a cash patient and will be expected to pay for services at the time they are rendered.**

I have read and agree to the above terms.

Patient Signature

Date

Health Ins
Liability Ins
Med-Pay Ins

Personal Injury Insurance Information

Patient _____ Accident Date _____

Attorney Information

Name: _____ Phone: _____

Address: _____

Auto Insurance Information

Other Party's Insurance Information

Company _____ Company _____

Policy #: _____ Policy #: _____

Claim #: _____ Claim #: _____

Phone #: _____ Phone #: _____

Adjuster: _____ Adjuster: _____

Address _____ Address _____

(For Office Use Only - Questions to Ask Attorney)

1. Does Liability look questionable? Yes No
2. Is the insurance policy active and will cover this accident? Yes No
3. Was a police report filed? Yes No
4. Were there any witnesses? Yes No
5. Amount of property damaged _____
6. Were there other people in the car? Yes No How Many? _____
7. Is there Med-Pay? Yes No What amount? _____
Limits? _____

Med-Pay Verified Date _____ Spoke to _____
_____ Initial

AUTO ACCIDENT CHECK LIST

Patient Name: _____

____ Drivers License

____ Any Hospital Reports (Optional)

____ Health Insurance Card (Optional)

____ Pink Accident Description

____ Assignment of Benefits (Signed)

____ Copy of Police Accident Report

____ Copy of Auto Insurance Card (Driver's)

____ Claim # _____

____ Insurance of Other Driver

Name of Driver _____

Insurance Company _____

Phone _____

Claim # _____

Policy # _____

Address to Mail Information _____

____ Attorney Information _____

Name _____

Phone _____

Address _____

Fax _____

____ Attorney Business Card (Optional)