PERSONAL INJURY CASE PACKET

We want to thank you for choosing Nevy Health! We understand that personal injuries are difficult and confusing and we will do everything we can to help you through your case. We are committed to getting you back to optimal health

WHAT WE NEED FROM YOU FOR YOUR CASE:

- ❑ Declarations sheet from your insurance company, this is your policy summary page that contains the insured's name and address, policy period and limits, or other key information about your policy.
- ❑ Copy of the police report, or report number and any pictures that you may have taken.
- ❑ Attorney information.
- ❑ Responsible party's name, claim number and policy number for responsible party's insurance.
- ❑ Responsible party's insurance adjuster's name and contact information.
- ❑ Claim number and policy number for your insurance.
- ❑ Claim adjuster's contact details.

Please take the time to review and fill out the required information on the following pages:

Page 2, Intake form: Please provide all required information to create a patient demographic file for your treatment.

Page 3, Intake form, Consent to Care, and Policy acknowledgments: Please sign and initial acknowledgment of our clinic policies. Failure to sign may disrupt your ability to be treated in our office

Pages 4 & 5, Personal injury Treatment Agreement: Please review and sign with your Attorney. Failure to sign/accept this Agreement may disrupt your ability to be treated under a Personal Injury case. Please complete & return via Fax, 480 494-5770, or Mail to:

Pentz Health Services LLC dba Nevy Health
6402 E. Superstition Springs Blvd Suite 123
Mesa, AZ 85206

Page 6, Accident Details: Please be as detailed as possible, information that is withheld or forgotten may stretch out your case.

Page 7 & 8, Health History: Please list problem areas related to the accident and provide as much information as possible.

Page 9, Review of Systems: Please list all issues you may be experiencing in relation to this accident.

INTAKE & REQUIRED INFORMATION

Please fill this form out completely. All fields are required information – Mark non-applicable fields as "N/A"

Name:____ Date: ______/______/______

(Last, First)

Mailing Address:_______________________________________ ____________ ______ ____________

City State Zip Code

Phone # (Cell/Home/Work):_____________________ Alternate Phone # (Cell/Home/Work):______________

SSN #: ______-______-______ Email Address:______________________________

Date of Birth: ______/______/______ Phone#:(______)______-______

Gender: □ Male □ Female

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated / □ Minor

Do you have children? □ Yes □ No If yes, how many?__________

Occupation:______________________________ Employer:______________________________

Primary Care Doctor? □ None ____________________________

Women: Any chance you could be pregnant? □ Yes □ No

How did you hear about our clinic?____

EMERGENCY CONTACT

Full Name:______________________________ Relationship:______________________________

Primary Phone #:(_____)______-______ Alternate Phone #:(____)______-______

INSURANCE INFORMATION:

Please provide us with the appropriate insurance information:

YOUR AUTOMOBILE INSURANCE CARRIER:

Primary Insurance Carrier:____

Primary Insured/ Policy Holder Name:______________________________________

Address: ____

Claim #:_______________________________________ Policy #:____________________

Claim Representative:____

Telephone:(____)______-______Fax:(____)______-______

Med-Pay Benefits: □Yes □No Un-Insured (UM) Benefits: □ Yes □ No Under-Insured (UIM) Benefits: □ Yes □ No

Have you signed a selection waiver of benefits? □ Yes □ No □ Unsure

Are you a full time Student? □ Yes □ No Do you reside with a relative? □ Yes □ No

YOUR ATTORNEY: (N/A □)

Name:__________________________________ Legal Assistant: ________________________

Address:____

Telephone:(____)______-______ Fax:(____)______-______

ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER:

Primary Insurance Carrier:____

Primary Insured/ Policy Holder Name:______________________________________

Address: ____

Claim #:_______________________________________ Policy #:____________________

Claim Representative:____

Telephone:(___)______-______ Fax:(____) ______-______

*Name:*______________________________

<u>YOUR</u> COMMERCIAL HEALTH INSURANCE COMPANY: (N/A □)

Primary Insurance Carrier:____

Primary Insured/ Policy Holder Name:____

Relationship to Patient: ___________________________________ Date of Birth: _______/______/______

Policy ID:___________________ Group #:_____________

Telephone:(____)______-______ Fax:(____)______-______

By signing below you acknowledge and accept that Pentz Health Services LLC dba Nevy Health will only bill your health insurance under specific criteria such as, but not limited to, your loss of liability insurance or you are under insured. These criteria are up to Pentz Health Services LLC dba Nevy Health's sole discretion.

Patient Printed Name:____Date:_______/______/______

Patient Signature (or Parent/ Guardian, if minor)____

If a patient is not yet 18 years old, a parent or guardian must sign.

ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to Pentz Health Services LLC dba Nevy Health all insurance benefits, if any, payable for services rendered to my minor child or myself. I understand I am financially responsible for all charges whether or not paid by insurance.

Patient Printed Name:____Date:_______/______/______

Patient Signature (or Parent/ Guardian, if minor)____

If a patient is not yet 18 years old, a parent or guardian must sign.

FINANCIAL POLICY

I understand that I am responsible for paying all deductibles, co-payments and co-insurance, and any non-covered services at the time of service. If I receive an insurance check, I agree to bring that check to the office within 7 business days. If the account is over 30/60/90 days past due, unpaid balances will be referred to a collection agency for resolution. I understand I will be assessed any and all collection fees incurred by the clinic.

Medicare Patients: Medicare doesn't cover everything. If you need certain services Medicare doesn't cover, you'll have to pay for them yourself unless you have other insurance or you're in a Medicare health plan that covers them.

You may get a written notice called an "Advance Beneficiary Notice of Non-coverage" (ABN) from your doctor or other health care provider. However, an ABN isn't required for items or services that Medicare never covers.

____________________ (initials)

CONSENT TO CARE

As a patient in this office, I have the right to know the types of treatment Pentz Health Services LLC dba Nevy Health could possibly use and any complication/side-effects to such treatment. In rare cases, underlying physical defects, deformities or pathologies, may render the patient susceptible to injury. I am responsible for informing my doctors about any conditions, diseases, illnesses, etc. Pentz Health Services LLC dba Nevy Health will not provide specific treatments if they are aware that such care may be contraindicated. I hereby allow treatment to be rendered to myself by Pentz Health Services LLC dba Nevy Health.

____________________ (initials)

APPOINTMENT REMINDER POLICY

I grant permission to be contacted to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, texts, or health information to me as an extension of my care in this office.

____________________ (initials)

MISSED APPOINTMENT POLICY

I understand there will be a $50.00 fee charged for ALL appointments that are not canceled or rescheduled with a minimum of 24 hours advance notice. I will notify Pentz Health Services LLC dba Nevy Health as soon as possible to cancel an appointment.

____________________ (initials)

TREATMENT FOR PERSONAL INJURY AGREEMENT

DATE: ______/______/______

____(“***PATIENT***”), will pay directly to Pentz Health Services LLC dba Nevy Health (“**PROVIDER**”) all amounts that may be due or owed for all medicines and/or other services provided to **PATIENT** by **PROVIDER** in connection with **PATIENT’S** treatment for and/or recovery from the personal injuries from **PATIENT** suffered on ___/______/______.

The purpose of this agreement is solely for the protection of **PROVIDER** and its **ASSIGNEES** for the period during which **PROVIDER** or **ASSIGNEE** is awaiting payment for the services provided in connection with this Agreement.

*Should **PATIENT** have an **ATTORNEY**:*

PATIENT hereby authorizes and directs, __________________________________(“**ATTORNEY**”), to withhold such sums from any settlement, judgment, court ruling, or verdict to compensate **PROVIDER** or **PROVIDER’S** designated assignee (“**ASSIGNEE**”). **ATTORNEY** shall tender payment in full to **PROVIDER** or assignee before disbursing any payment to **PATIENT**.

PATIENT and **ATTORNEY**, if assigned, hereby acknowledges the following**:**

- That **PROVIDER** reserves the right to assign all or any portion of this Agreement including, but not limited to, a Medical Lien underlying this Agreement, each an “assignment”, as **PROVIDER**, in sole and absolute discretion, shall determine.
- **PATIENT** is, and will remain, directly and fully responsible to **PROVIDER** or **ASSIGNEE** for all bills submitted for the services provided to **PATIENT**.
- The amount **PATIENT** owes in connection with this Agreement is not contingent upon any settlement, judgment, court rulings, or verdict that **PATIENT** may eventually recover and/or receive.
- **ATTORNEY** is authorized to disclose information regarding the status of **PATIENT** case to **PROVIDER** and/or **ASSIGNEE**.
- It is **PATIENT’S** responsibility to keep **PROVIDER** and/or **ASSIGNEES** notified in the event **PATIENT** changes attorneys.
- It is **PATIENT’S** responsibility to inform any new attorney of the existence of this Agreement document. Upon such circumstance, **PATIENT’S** new attorney shall either provide a signed copy of this Agreement or notify **PROVIDER** and/or **ASSIGNEE** within 48 hours that this agreement will be upheld and honored by the new attorney. If **PROVIDER** and/or **ASSIGNEE** is not provided with an updated and signed copy or notification, **PATIENT** will be responsible for immediate payment to **PROVIDER** and/or **ASSIGNEE**.
- That amounts owed to **ASSIGNEES** with respect to any assignment will not necessarily be or equal the amount that **PROVIDER** has or will bill to **PATIENT**. Rather, any negotiated payments between **PROVIDER** and **ASSIGNEE** will not in anyway affect **PATIENT’S** financial obligations as set forth in this agreement.
- That in the event **PROVIDER** enters into any assignment, **PATIENT** and **ATTORNEY** will continue to be bound by this Agreement and will be bound directly to **ASSIGNEE** as though **PATIENT** entered into this Agreement directly with **ASSIGNEE**.
- That **PATIENT** shall remain liable to **ASSIGNEE** for the full billed charges and/or value of any services provided to the **PATIENT** with respect to this Agreement.
- That **PROVIDER** may release the minimum necessary amount of **PATIENT’S** Protected Health Information to **ASSIGNEE** in the event **PROVIDER** enters into an assignment under this Agreement.
- Should **PATIENT** move and change address without notifying **PROVIDER**, **PATIENT** gives permission to **ATTORNEY** to provide updated address information directly to **PROVIDER**

_______**PATIENT** Initials ______**ATTORNEY** Initials

TREATMENT FOR PERSONAL INJURY AGREEMENT *(continued)*

Furthermore, **PATIENT** affirmatively represents and agrees that:

- In the event that **PATIENT** has Health Insurance coverage, other than any automobile or other type of liability insurance, **PATIENT** does not intend to use such coverage to pay for the cost of **PATIENT'S** care to be provided by **PROVIDER.**
- **PROVIDER** will treat **PATIENT** on a lien basis, **PATIENT** agrees to forego submission to any Health Insurance, other than automobile or other liability insurance, and allow **ATTORNEY** to pay **PROVIDER** all expenses out of gross settlement proceeds.
- **PATIENT** shall not submit, without express permission from **PROVIDER** the medical bills arising from this Agreement for payment to any private health plan or state or federal government sponsored health plan, including but not limited to Medicare and CHAMPUS.
- **PATIENT** will list **PROVIDER** on any settlement draft(s) / check(s). **PROVIDER** should be listed as "Pentz Health Services LLC dba Nevy Health"
- **PATIENT** will not, nor will **ATTORNEY**, assert a claim for a pro rata of attorney fees for collection of said settlement funds. **PATIENT**, nor **ATTORNEY**, will make a claim for a reduction of **PATIENT'S** medical expenses to **PROVIDER** under Samaritan v LaBombard or any Common Fund Doctrine

With respect to any services in connection with this Agreement, **PATIENT** hereby authorizes **PROVIDER** and/or **ASSIGNEE** to directly bill the services provided to any insurance company that may provide automobile / motorcycle / other vehicle, "med-pay" coverage and/or related benefits to which **PATIENT** may be entitled.

PATIENT understand that **PROVIDER** may assign this Agreement to a third party at any time. In the event this Agreement is assigned, **ASSIGNEE** will notify **PATIENT** and/or **ATTORNEY** in writing. Upon such an assignment, **ASSIGNEE** shall acquire all rights and remedies available to **PROVIDER** herein or at law.

If **PATIENT** or **ATTORNEY** refuses/fails to honor the terms in this Agreement, **PROVIDER** and/or **ASSIGNEES** will not await payment and **PATIENT** will be required to pay **PROVIDER** and/or **ASSIGNEE** in full.

PATIENT gives, by signing below, a durable Power of Attorney on behalf of **PROVIDER** to be able to endorse any draft/check on **PATIENT'S** behalf, so that any outstanding amount due or owed to **PROVIDER** can be satisfied without additional signature from **PATIENT**.

In the event **PROVIDER** enters into an assignment, **ASSIGNEE** shall have the right to endorse and deposit checks received with respect to the services provided in connection with the terms of this agreement.

By signing below, **PATIENT** represents that **PATIENT** has reviewed this Agreement, with **ATTORNEY** (if applicable), and agrees to all terms of this Agreement.

PATIENT Signature:____ Date: ______/______/______

PATIENT Printed Name:_____________________________________

By signing below, **ATTORNEY** agrees to all terms of this Agreement. **ATTORNEY** shall notify **PROVIDER** if discharged from representation, withdraws from representation, or closes the above **PATIENT'S** file without receiving any payments immediately within 48 hours of the severing of the relationship.

ATTORNEY Signature:____ Date: ______/______/______

ATTORNEY Printed Name:____

ANY PERSONS WITH QUESTIONS REGARDING THIS AGREEMENT PLEASE CONTACT OUR OFFICE. A FAX OR PHOTOCOPY OF THIS DOCUMENT SHALL BE CONSIDERED AS VALID AS THE ORIGINAL. THIS AGREEMENT AND FILED MEDICAL LIEN COVER THE FOREGOING CASE AND ANY OTHER LEGAL OR ADMINISTRATIVE ACTION RELATING TO THE SUBJECT INJURY OR CLAIM

*Name:*______________________________

ACCIDENT DETAILS

Date of Accident:____________________ Time of Accident: ____________ AM / PM

Specific location of accident:____

Describe in detail, in your own words, how the accident happened:____
____
____
____
____

Were you a: ◻ Driver ◻ Passenger ◻ Pedestrian ◻ Other

*If you were not that driver, who was driving the vehicle you were in?*_______________________________

Describe the vehicle you were in (year, make, model):____

Did the car you were in strike the other vehicle: Yes / No

If no, the vehicle you were in was struck from: ◻ Behind ◻ Front ◻ Side Impact ◻ Driver's Side ◻ Passengers Side

Were you wearing a seat belt? Yes / No Did an airbag deploy? Yes / No

Did the Police arrive at the scene? Yes / No Was a police report made? Yes / No

Traffic citations were issued to:
◻ You ◻ The driver of car you were in ◻ The driver of the other car ◻ No citations given

What direction was your car was heading: ◻ North ◻ East ◻ South ◻ West, on Street / Highway

What direction was the other car was heading: ◻ North ◻ East ◻ South ◻ West, on Street / Highway

Where did you go after the accident? Hospital, urgent care, home, work, other

Were you taken by ambulance? Yes / No If yes, to which hospital?___________________________

Address____Date of hospitalization_____________________________

Attending E.R Doctor_____________________________Treatment given__________________________________

Were X-Rays taken? Yes / No

Were any other tests performed?____

Please check any of the following symptoms you have noticed since the accident?

◻ Headache	◻ Middle Back Pain	◻ Lower Back Pain	◻ Ears Ring
◻ Neck Pain	◻ Chest Pain	◻ Lower Back Stiffness	◻ Buzzing in Ears
◻ Neck Stiffness	◻ Bruised Chest	◻ Radiating Pain	◻ Dizziness
◻ Sleeping Problems	◻ Bruising Anywhere	◻ Tingling in Legs	◻ Loss of Smell
◻ Depression	◻ Blurred Vision	◻ Tingling in Arms	◻ Loss of Taste
◻ Anxiety	◻ Sensitivity to Light	◻ Jaw Pain	◻ Any Burns
◻ Fainting	◻ Upper Arm Pain	◻ Upper Leg Pain	◻ Any Stitches
◻ Muscle Spasms	◻ Lower Arm Pain	◻ Lower Leg Pain	◻ Any Cuts

Other Symptoms not described above:____
____

Specific date and time of onset of symptoms**:**____
____
____
____

*Name:*___________________________

HEALTH HISTORY

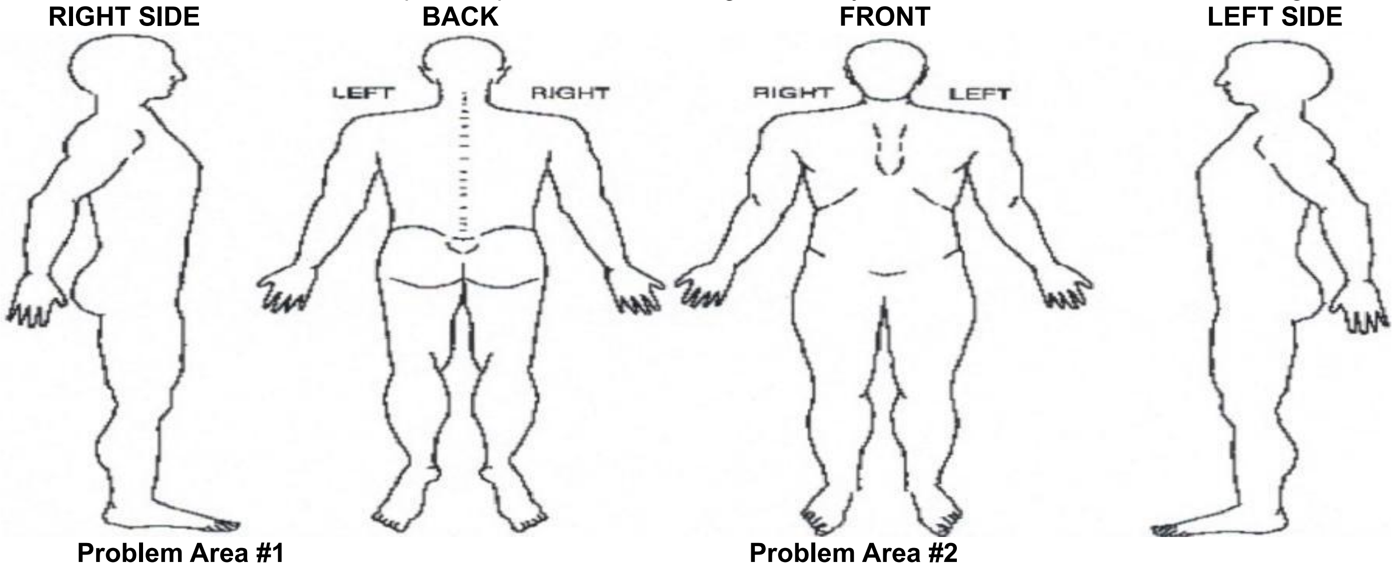
Do any of the following below interest you today? (Please circle all that apply)

Symptom Relief / Optimal Health / Massage / Weight Loss / Nutrition / Supplementation / Allergies / Other:

Indicate on the body diagram where you are experiencing symptoms:

N= Numbness **–** **S**=Sharp **–** **Z**=Spasms **–** **B**= Burning **–** **X**= Achy/Dull **–** **W**= Weakness **–** **T**= Throbbing

RIGHT SIDE **BACK** **FRONT** **LEFT SIDE**



Problem Area #1		**Problem Area #2**	
How did the pain begin?		How did the pain begin?	
Have you had this pain before?	Yes/No If yes #of times:	Have you had this pain before?	Yes/No If yes #of times
Date the pain started		Date the pain started	
How often do you feel it?	0-25% 25-50% 50-75% 75-100%	How often do you feel it?	0-25% 25-50% 50-75% 75-100%
Pain scale (0= no pain)	0 1 2 3 4 5 6 7 8 9 10	Pain scale (0= no pain)	0 1 2 3 4 5 6 7 8 9 10
Quality (Sharp, Stabbing, Numb)		Quality (Sharp, Stabbing, Numb)	
Does the pain travel	Y / N, if so where?	Does the pain travel	Y / N, if so where?
What increases pain?		What increases pain?	
What decreases pain?		What decreases pain?	
Have you had X-rays? / MRI?	Yes / No	Have you had X-rays? / MRI?	Yes / No
What time is the pain the worst?	Night / Morning / Mid day / NA	What time is the pain the worst?	Night / Morning / Mid day / NA

Problem Area #3		**Problem Area #4**	
How did the pain begin?		How did the pain begin?	
Have you had this pain before?	Yes/No If yes #of times:	Have you had this pain before?	Yes/No If yes #of times
Date the pain started		Date the pain started	
How often do you feel it?	0-25% 25-50% 50-75% 75-100%	How often do you feel it?	0-25% 25-50% 50-75% 75-100%
Pain scale (0= no pain)	0 1 2 3 4 5 6 7 8 9 10	Pain scale (0= no pain)	0 1 2 3 4 5 6 7 8 9 10
Quality (Sharp, Stabbing, Numb)		Quality (Sharp, Stabbing, Numb)	
Does the pain travel	Y / N, if so where?	Does the pain travel	Y / N, if so where?
What increases pain?		What increases pain?	
What decreases pain?		What decreases pain?	
Have you had X-rays? / MRI?	Yes / No	Have you had X-rays? / MRI?	Yes / No
What time is the pain the worst?	Night / Morning / Mid day / NA	What time is the pain the worst?	Night / Morning / Mid day / NA

*Name:*______________________________

HEALTH HISTORY

Please List any X-Rays, labs, or other tests (within the past five (5) years) Include date performed and the facility/doctor:

____
____
____
____
____
____

Psycho-Social History:

Changes to activities of daily living since the accident:____

Recreational / Exercise: Type:_______________Frequency:____x Week; Duration______Minutes / Hours

Sleep interrupted?_____Times x Night for ______Weeks / Months / Years

Work Routine / Duties under Duress	Able		Restricted		Unable	Comments
Sitting in an office chair	1	2	3	4	5	
Standing erect	1	2	3	4	5	
Climbing steps / stairs	1	2	3	4	5	
Stooping to pickup	1	2	3	4	5	
Crouching to pickup	1	2	3	4	5	
Kneeling to pickup	1	2	3	4	5	
Reaching overhead	1	2	3	4	5	
Lifting; waist to shoulder height	1	2	3	4	5	
Carrying objects, 100 feet	1	2	3	4	5	
Pushing	1	2	3	4	5	
Pulling	1	2	3	4	5	
Balance	1	2	3	4	5	
Crawling	1	2	3	4	5	
Reaching	1	2	3	4	5	
Handling of objects appropriately	1	2	3	4	5	
Finger / Hand strength and coordination	1	2	3	4	5	

*Name:*_______________________________

REVIEW OF SYSTEMS

Please indicate, by number, any that apply; 1 = Presently Have, 2 = Previously Had, 3 = Related to this accident

General
__Allergy
__Chills
__Convulsions
__Dizziness
__Fainting
__Fatigue
__Fever
__Headache
__Sleep Loss
__Weight Loss
__Nervousness
__Depression
__Neuralgia
__Numbness
__Sweats
__Tremors

Eyes, Ears, Nose, Throat
__Asthma
__Colds
__Sore Throat
__Deafness
__Gum Trouble
__Dental Decay
__Earache
__Ear Ringing
__Ear Discharge
__Sinus Infection
__Enlarged Glands
__Enlarged Thyroid
__Nose Bleeds
__Failing Vision
__Farsightedness
__Nearsightedness
__Hay Fever
__Hoarseness
__Nasal Obstruction

Musculoskeletal
__Arthritis
__Bursitis
__Foot Trouble
__Hernia
__Low Back Pain
__Lumbago
__Neck Pain
__Shoulder Blade Pain
__Pain or Numbness in:
  __Shoulders
  __Arms
  __Elbows
  __Hands
  __Hips
  __Legs
  __Knees
  __Feet
__Painful Tailbone
__Poor Posture
__Sciatica
__Spinal Curvature

Genitourinary
__Bed-wetting
__Blood in Urine
__Frequent Urination
__Inability to control bladder
__Kidney infection or stones
__Painful Urination
__Prostate Trouble
__Pus in urine
__Painful Menstruation
__Hot Flashes
__Irregular Cycles
__Lump in Breasts

Cardiovascular
__Hardening of Arteries
__High blood pressure
__Low blood pressure
__Pain over heart
__Poor circulation
__Rapid heart beat
__Slow heart beat
__Swelling on ankles

Respiratory
__Chest Pain
__Chronic cough
__Difficulty breathing
__Spitting up blood
__Spitting up phlegm
__Wheezing

Gastrointestinal
__Belching or gas
__Colitis
__Colon Trouble
__Constipation
__Diarrhea
__Difficult digestion
__Distention of abdomen
__Excessive hunger
__Gall bladder trouble
__Hemorrhoids
__Intestinal worms
__Jaundice
__Nausea
__Pain over stomach
__Poor appetite
__Vomiting
__Vomiting blood

Are you currently taking any medication as a result of the accident? Yes / No If yes, Please describe below,
Please include medications and dosage, frequency, and for what condition?
____
____

Please list all medications and dosage for all other than those since the accident: ___________________________
____

Vitamins, herbs, supplements (nasal sprays, creams, etc):____
____

Please list any allergies to medications, foods, or other:____
____

I certify that all of the above questions were answered accurately. I understand that providing incorrect information may be dangerous to my health.

Patient Printed Name:____Date:________________

Patient Signature (or Parent/ Guardian, if minor)____

If a patient is not yet 18 years old, a parent or guardian must sign.