

Great Wall Chinese Medicine and Acupuncture



3225 N 75th St Ste 115, Scottsdale, AZ 85251
 604 W Warner Rd Ste B-1, Chandler, AZ 85225
 P: (480)429-8881 F: (480)429-8882

www.chinesedrs.com gwcmreception@chinesedrs.com

MOTOR VEHICLE ACCIDENT FORM

AUTO ACCIDENT HISTORY			
Patient's Name: (Last) (First) (Middle)			Today's Date:
1. Date of Accident (mm/dd/yyyy):		Time of Accident: AM / PM	
2. Place where accident occurred:			
3. Where were you seated? Driver Passenger Rear-seat Other:			
4. Are you the at fault party? Yes No		5. Who owns the car?	
6. Year & Model of your car:		Year & Model of the other car involved:	
7. What was the approximate damage done to your car? \$			
8. Visibility at time of accident: Poor Fair Good Other:			
9. Road conditions at time of accident: Icy Rainy Wet Clear Dark Other:			
10. Type of Accident: Head-on Collision Broad-side Collision Front-Impact Rear-end car in front Rear Impact Non-collision			
11. Were you aware of the approaching collision prior to impact, or did it catch you by surprise? Aware Surprise			
12. Were seatbelt wore? Yes No		13. Did you brace for impact? Yes No	
14. Did the airbags inflate? Yes No Don't have airbags			
15. What was your headrest positioned? Low Middle High			
16. Was your car breaking? Yes No		17. Was your car moving at the time of impact? Yes No	
18. How fast would you estimate you were going?		Mph	
19. How fast would you estimate the other car was going?		Mph	
20. Head/body position at the time of impact: Head turned left / right Body straight in sitting position Head looking back Head straight forward Body rotated left / right Other:			
21. Did you lose consciousness upon impact? Yes No			
22. Did you experience a flash of light or explosion in your mind? Yes No			
23. Were you able to get out of the car and walk unaided? Yes No			
24. Were you wearing a hat or glasses? Yes No			
25. Did the police come to the accident scene? Yes No		Is there a police report? Yes No	
26. Did you go to the hospital or urgent care? Yes No When? Immediately ___ hours later ___ days later			
27. How did you get there? Ambulance Police Drove own car Someone drove me			

AUTO ACCIDENT HISTORY (continue)

27. Describe the accident in your own words:

28. List all hospital, urgent care, and doctors visited for the accident (please provide exam results and medical records if possible) :

1) Facility: _____ Date: _____

Examination (X-rays, MRI, CT scan, etc.):

Diagnosis:

Treatment:

2) Facility: _____ Date: _____

Examination (X-rays, MRI, CT scan, etc.):

Diagnosis:

Treatment:

3) Facility: _____ Date: _____

Examination (X-rays, MRI, CT scan, etc.):

Diagnosis:

Treatment:

Other facilities and treatments: _____

29. Have you miss time from work since the accident? Yes No If yes, ____ hours or ____ days

30. Any previous accident or major injuries (list dates):

30. Other notes:

CLAIM DETAIL

Insurance Company:	Claim #:
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Claim Adjuster and Contact Info:

Uninsured Coverage:	Underinsured Coverage:
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Other Party's Insurance Company:	Claim #:
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Other Party's Claim Adjuster and Contact Info:

Attorney and Contact Info:	Other Party's Liability Coverage:
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INSURANCE PAYMENT POLICY AND AGREEMENT

Patient's Understanding and Responsibility of Payment for Treatments:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand that any amount all services rendered me is charged directly to me and that I am personally responsible for payment. However, for services covered by my insurance, I understand that GWCM will prepare any necessary reports and forms to assist me in making collection from the insurance company and any amount authorized to be paid directly to GWCM will be credited to my account upon receipt.

Insurance Coverage and Insurance Billing:

Upon my initial visit, GWCM will review with me my insurance, insurance coverage and out-of-the-pocket payment (such as fixed-amount COPAY per my covered insurance policy). GWCM will also review with me their various discounted payment plans for quantity pre-payments.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in-full and immediately upon presentation of the appropriate statement. I understand and agree that full payment is required at time services are rendered if my insurance does NOT cover.

Assignment of Insurance Payment Benefits:

I hereby authorize and direct my insurance carrier, including private insurance and any other health/medical plan, to issue payment check(s) directly to Great Wall Chinese Medicine for services rendered. **I understand that I am responsible for any amount not covered by insurance.**

Authorization to Release Information:

I hereby authorize Great Wall Chinese Medicine to: 1.) Release any information necessary to insurance carriers regarding my illness and treatments; 2.) Process insurance claims generated in the course of examination or treatment; and 3.) Allow a photocopy of my signature to be used to process insurance claims. This authorization will remain in effect until revoked by me in writing.

I have requested services from Great Wall Chinese Medicine on behalf of myself and/or my dependents, and understand that by making this request that I become fully responsible for any and all charges incurred in the course of authorized treatment. I understand that I will be responsible for any court costs or collection fees should it become necessary for GWCM to take action for services/supplies rendered.

Possible Treatment Procedures:

99203 New Patient Consul 30min \$145	97810 Acu w/o ES initial \$95	97039 Unlisted Therapeutic \$115
99213 Estab Patient Consul 15min \$80	97811 Acup w/o ES add \$50	97110 Therapeutic Exercise \$40
99214 Estab Patient Consul 25min \$120	97183 Acu w/ ES initial \$115	97026 Infrared Heat 15min \$20
99212 Office visit 10min \$50	97184 Acu w/ ES add \$55	97140 Manual Therapy 15 min \$65

I have read, understand, and agree to Great Wall Chinese Medicine **INSURANCE PAYMENT POLICY and AGREEMENT.**

Patient Signature	Patient Name (Print)	Date
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Responsible Party Signature	Responsible Party Name (Print)	Relation to Patient	Date
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**AUTHORIZATION FOR MEDICAL RECORDS RELEASE TO ATTORNEY
AND FOR PAYMENT LIEN ON CLAIMED CASE OF ACCIDENT**

I, _____ (Patient Name) under treatment by Dr. Qingsong Xiao at Great Wall Chinese Medicine (GWCM), for my claimed case of accident (Claim #: _____), fully understand and agree that I am fully responsible for all treatment bills submitted by GWCM for services rendered. I fully agree that this AUTHORIZATION is made for financial protection of the said doctor, and in consideration of often delayed medical payments to GWCM. I further understand that such payment is not contingent upon on any settlement, judgment or verdict by which I may eventually recover said fee.

I, therefore, hereby authorize GWCM to furnish to the undersigned Attorney, with a full report of their examination, diagnosis, treatment prognosis, etc., of myself in regard to the accident in which I was involved.

I, hereby authorize and direct the undersigned Attorney, to pay directly to said doctor such sums as may be due and owing for medical services rendered me both by reason of this accident and by reason of any other bills that are due GWCM, and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to the undersigned Attorney or myself as the result of the injuries for which I have been treated or injuries in connection therewith. I, said patient, authorize the undersigned Attorney to divulge insurance information and status report to GWCM.

Patient Signature

Date

The undersigned being Attorney of Record for the above captioned patient hereby agrees to observe all the relevant terms of the above, and to agree to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect the said accident patient and said doctor above named.

Attorney Signature

Attorney Name (Print)

Date

GREAT WALL CHINESE MEDICINE MVA VOICE RECORDING GUIDLINE

First Visit Questions:

1. Name and Todays date
2. Reason for Visit
MVA:
Ask for details not mentioned in the MVA paperwork.
WC:
Ask for details not mentioned in the WC paperwork.
3. How do you feel the injury has affected your life? (Example: Unable to work Attend social activities? Exercise?)
4. What was your overall pain level before the accident took place? (Range of 1-10)
5. What is your overall pain level today? (Range of 1-10)
6. What are you hoping to achieve or what are your personal goals with treatment?

General Visit Questions:

1. Name and todays date
2. How did you feel before todays treatment?
3. How did you feel immediately following your last treatment?
4. Do you feel like the treatment you are receiving is helping over all?
5. What areas are you most concerned? Where do you feel the most pain today?
6. Any new areas or symptoms since your last visit?
7. Any issues with range of motion? (What are the restrictions. Please mention %)
8. How is this pain effecting your daily life? Any limitations? (Example: unable to sit too long, walk far distances or drive.)
9. Have you seen any other providers/doctors since your last treatment? (Only ask if marked “yes” on progress sheet) If yes, who have you seen?
10. Have you made any medication changes since your last visit?

4 Week Update: (ADD only for 4-week update)

1. Name and Todays Date
2. Do you feel like treatment helped you overall? (Only ask if patient marked “yes” on progress sheet)
How?
3. How did you feel immediately following your last treatment?
4. What areas are you most concerned? Where do you feel the most pain today?
5. Any new areas or symptoms since your last visit?
6. Range of motion details. If limited range of motion, talk about those areas. From certain percentage to percentage.
7. How much have your symptoms interfered with your work day?
8. How much have your symptoms interfered with your social/family activities?
9. In general, how would you say your overall health is right now? (Excellent, Good, Fair, Poor?)
10. Have you seen any other doctors or had any changes in your medications?