MVA Accident Questionnaire

Name __________________________________________  Date _______________________

Date of Accident _____________________________  Time of Accident ___________________

Road conditions at time of accident ________________________________________________

Were you the driver?     YES   NO  Were you the passenger?    YES   NO

Where were you seated in the vehicle?  FRONT      BACK      LEFT      RIGHT

Were you transported by Ambulance?  YES   NO

Were you seen in the Emergency Room?  YES   NO

Were you admitted to the Hospital?  YES   NO

Were X-rays or an MRI done?  YES   NO

Patient Car Year ____________  Make ____________  Model ____________  Speed __________

Other Car Year ____________  Make ____________  Model ____________  Speed __________

Please draw your accident

---

Please describe your accident

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Describe your injury (injuries)

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
PLEASE PRINT CLEARLY

Name _______________________________________________
If married, Maiden Name _______________________________
Social Security # ______________________________________
Date of Birth  month _______ day _______ year ______
Marital Status (circle one)   married     single      domestic partner
Gender    male     female
Race __________________
Ethnicity _____________   Languages spoken ______________
Home address ________________________________________
    City _______________  State ________  Zip_________
Mailing Address (if different) __________________________
    City________________  State ________ Zip ________
Home Phone   (_______)  _______________________________
Mobile Phone (_______)  _______________________________
Work Phone    (_______)  _______________________________
Personal email  _______________________________________
Pharmacy ______________________________
    Phone _________________________________________
Who referred you to Dr. Zegarelli?
   _______________________________________________

Responsible Party on this account self other ___________
If Other:  Name ________________________________
Relationship to Patient __________________________
Mailing Address _______________________________
    City _______________  State ________  Zip________
Phone (_______)  ___________________________________
Email _____________________________________________

Emergency Contact responsible party other
If Other: Name ______________________________________
Relationship to Patient __________________________
Mailing Address _______________________________
    City _______________  State ________  Zip________
Phone (_______)  ___________________________________
Email _____________________________________________

Primary Insurance Co. ____________________________
Plan Name _______________________________________
Plan Type ________________________________________
Group Name ______________________________________
Group # _________________________________________
Policy # (ID #) ___________________________________
Start/Effective Date _______________________________
Office Copay $ ____________________________
Lawyer’s Name ___________________________________
    Phone _________________________________________
The reason for my visit today is:  (circle one)
Medical       Auto accident     Worker’s Comp  Other

Have you had the following:  NO  WANT IT
    Flu shot    _______ _______
    Pneumonia shot _______ _______
    Hepatitis B Vaccine _______ _______
    Shingles vaccine _______ _______
    Other _______ _______

List the medications you are taking:

Prescription:
    __________________________ Dose __________________________
    __________________________ Dose __________________________
    __________________________ Dose __________________________
    __________________________ Dose __________________________
    __________________________ Dose __________________________

Over the Counter:
    __________________________ Dose __________________________
    __________________________ Dose __________________________
    __________________________ Dose __________________________

Vitamins/Herbs/Minerals/Other:
    __________________________ Dose __________________________
    __________________________ Dose __________________________
    __________________________ Dose __________________________
### Current Problems:

Please list all current problems you are experiencing. List the most severe first, the second most severe next, etc.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Date of Onset</th>
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Do you have, or have you ever had, any of the following? (check all that apply)

- [ ] head trauma
- [ ] blindness, cataract, glaucoma
- [ ] trouble hearing, hearing aids
- [ ] allergic rhinitis, sinus infections
- [ ] dentures
- [ ] heart problems, angina, murmur
- [ ] high blood pressure, low blood pressure
- [ ] aneurysm
- [ ] asthma
- [ ] bronchitis, pneumonia, COPD, emphysema
- [ ] cirrhosis, gallbladder disease
- [ ] GERD, Heartburn, hiatal hernia, ulcer
- [ ] hepatitis, jaundice
- [ ] hemorrhoids
- [ ] hernia
- [ ] incontinence
- [ ] kidney disease, UTI
- [ ] bladder disorder
- [ ] diabetes
- [ ] heart disease
- [ ] mental illness
- [ ] June disease
- [ ] hypertension
- [ ] high cholesterol
- [ ] arthritis
- [ ] gout
- [ ] skeletal injury
- [ ] dermatitis, moles, psoriasis
- [ ] epilepsy, seizures
- [ ] chronic fatigue syndrome
- [ ] amnestic, GNM, minor cerebral ischemic injury
- [ ] amnestic, GNM, minor cerebral ischemic injury
- [ ] SIDS
- [ ] stroke, TIA
- [ ] AIDS, HIV
- [ ] TB
- [ ] Other: _______________________________________

### Surgeries:

<table>
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<th>Year</th>
<th>Type</th>
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### Hospitalization History:

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<th>Year</th>
<th>Length of Stay</th>
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Do you use tobacco?  

- [ ] Yes
- [ ] No

Do you drink alcohol?  

- [ ] Yes
- [ ] No

Do you use illicit drugs?  

- [ ] Yes
- [ ] No

Do you eat healthy meals?  

- [ ] Yes
- [ ] No

Do you regularly exercise?  

- [ ] Yes
- [ ] No

Do you take daily aspirin?  

- [ ] Yes
- [ ] No

Does your home have smoke detectors?  

- [ ] Yes
- [ ] No

Do you keep firearms in your home?  

- [ ] Yes
- [ ] No

Do you wear seatbelts?  

- [ ] Yes
- [ ] No

Have you had exposure to STDs?  

- [ ] Yes
- [ ] No

So you practice safe sex?  

- [ ] Yes
- [ ] No

### If Female:

- [ ] Date of onset of last mensus: __________
- [ ] Have you ever been pregnant? ___________
- [ ] Have you given birth? ___________

Have any of your family had any of the following?  

- [ ] arthritis
- [ ] asthma
- [ ] bleeding disorder
- [ ] heart disease
- [ ] diabetes
- [ ] high cholesterol
- [ ] hypertension
- [ ] lung disease
- [ ] mental illness
- [ ] stroke
- [ ] cancer
- [ ] if yes, what type? ____________________________
- [ ] other: _______________________________________

List all allergies (if none, check the blank below):  

- [ ] No known allergies
- [ ] Other: _______________________________________

### Medications

- [ ] _______________________________________

### Foods

- [ ] _______________________________________

### Other

- [ ] _______________________________________

I acknowledge that I have been provided KPMC’s Notice of Privacy Practices: ____________________________

Signature of Patient or Personal Representative: ____________________________

Date: ____________________________
No Show and Cancellation Policy
I understand that if I fail to show up for my appointment without 24 hours notice I may be subject to a "No Show" fee that is not billable to insurance. I also understand that if I fail to show up for my appointment without notice of cancellation 3 times, any future appointments will be made when the appointment is pre-paid. This is non-refundable and will NOT be credited to future appointments.

Financial Policy
I understand that charges incurred for services rendered by Kiest Park Medical Clinic or Smart Living Medical Center are my responsibility, regardless of insurance coverage. I understand and agree that insurance policies are an agreement between the insurance carrier and me; and not between my insurance carrier and Kiest Park Medical Clinic or Smart Living Medical Center. Furthermore, I understand KPMC/SLMC will prepare any necessary reports and forms to assist in making collections from my insurance company and that any amount authorized to be paid directly to KPMC/SMLC will be credited to my account upon receipt.

Assignment will be accepted for all insurance with which KPMC/SMLC participates. It is my responsibility to provide this office with accurate insurance information and to notify KPMC/SMLC of any changes in health insurance coverage. If I have any questions on network status/participation with my insurance, it is my responsibility to contact the customer service number on my insurance card.

I understand if any insurance company sends a check or reimbursement to me; THE CHECK DOES NOT BELONG TO ME. I am to bring the check and Explanation of Benefits to KPMC/SMLC.

Patient Responsibility:
If my insurance has an office co-payment, co-insurance, or deductible that has not been satisfied, I must pay this at the time of my appointment. I understand that charges for professional services rendered are due and payable immediately. Any amount unpaid by my insurance company is my responsibility and is due immediately upon notification of the denial by my insurance company. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. All costs for my care is my responsibility. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect.

Billing: Know your insurance policy
I understand that I am responsible for any rejected claims, non-covered expenses, deductibles, co-insurance/copayments. Cash, money order, Visa and Master Card are acceptable means in which to pay the balance.

I understand that at times, no matter how diligent KPMC/SLMC's billing might be, my insurance company might decline a claim for services. In that event, it is most effective for me to contact the insurance company since I am their paying customer. KPMC/SLMC's billing department will be glad to assist me, but I may be asked to intervene as that is the most effective means of settling disputes with my insurance company.

If there remains an unpaid balance and I make no payment or make no contact as the responsible party despite all KPMC/SLMC's efforts to contact me, then my account could be turned over to a collection agency or pursued legally.

Informing our patients about our financial policy assists us in providing the best service to our patients. Thank you for taking the time to read this policy statement. Should you have further questions or comments, please kindly contact our Business Office Supervisor.

I hereby understand the financial policy of this practice. I guarantee payment of all charges incurred for the account of the patient named below. I further agree to pay any attorney's fees, court costs, and related collection fees incurred. I also agree that my employer may be contacted to verify employment status.

Patient name/Signature ____________________________________________________________ Date ________________
Guarantor/Responsible Party Signature ______________________________________________ Date ________________
ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chosen action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Signature ____________________________
Date ____________________________
THIS NOTICE TELLS YOU HOW YOUR MEDICAL RECORD MAY BE USED AND SHARED AND HOW YOU MAY GET THIS INFORMATION.

PLEASE READ IT CAREFULLY.

OUR PLEDGE TO YOU
Your health information is something that Kiest Park Medical Clinic/Smart Living Medical Center (KPMC) has always worked to keep private. We also are ethically and legally bound to keep it confidential under state and federal laws.

WHAT IS THIS DOCUMENT?
This document, called a Notice of Privacy Practices, tells you how we may use and share your health information. This includes using and sharing it so that we may provide you with health care and be paid for it, and so that we may run our business and follow state and federal legal rules. We must follow the terms of this notice.

WAYS WE MAY USE AND SHARE YOUR HEALTH INFORMATION WITHOUT YOUR PERMISSION.

Treatment. We will use and share your medical record for your care.
Example: Doctors, dentists, students, medical residents or other university workers may read your record to learn if a treatment is working. Your medical information also may be shared with doctors or dentists outside KPMC to decide the best treatment for you.

Payment. We may use and share your medical information to be paid for the care and services we provided you.
Examples: We may contact your insurance company to learn if a service is covered. We may bill you or your insurance company for the services we provide.

Health-care Operations. We need to use and share your health information to run our health-care business. We may use or share your information for several reasons.
Examples: Our staff may use your medical information to make sure that you and other patients get the best possible care. Medical students may see the information as part of their training. Others on our staff may use it to make sure that billing is being done correctly. In certain special conditions, other health-care providers may get your information from us to run their businesses.

Business Associates. We may share your medical information with another company or organization, called a "business associate" that we hire to provide a service to us or on our behalf. We will only share your information if the business associate has agreed in writing to keep it private.
Example: A company that submits bills on our behalf to your insurance company.

Appointment Reminders. We may contact you to remind you of an appointment or to change one. We may also let you know that it is time for a follow-up appointment or a regular check-up.

Health-Related Benefits, Services and Treatment Alternatives. We may tell you about interesting health-related benefits or services such as newsletters, announcements, possible treatments or alternatives.

Required Disclosures. The Secretary of the Department of Health and Human Services may investigate privacy violations. If your health information is requested as part of an investigation, we must share your information with the Secretary of the Department of Health and Human Services. We will share your information if they ask for it as part of an investigation of a privacy violation. Under the same laws, we must give you information in your medical record. We are allowed to keep some information from you.

Required by Law. We must share medical information if federal, state or local law says so.

Public Health and Safety. We may share your medical information for public health reasons. These include:
- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report information to the FDA about the products it oversees;
- to let you know that you may have been exposed to a disease or may be at risk for getting or spreading a disease or condition;
- to your employer in certain limited instances.

Abuse and Neglect. The law may require us to report suspected abuse, neglect or domestic violence to state and federal agencies. Your information may be shared with these agencies for this purpose. Generally, you will be told that we are sharing this information with these agencies.

Health Oversight Activities. Certain health agencies are in charge of overseeing health-care systems and government programs or to make sure that civil rights laws are being followed. We may share your information with these agencies for these purposes.

Legal Proceedings. If a court or administrative authority orders us to do so, we may release your health records. We will only share the information required by the order. If we receive any other legal request, we may also release your health record. However, for other requests we will only release the information if we are told that you know about it, had a chance to object and did not.

Law Enforcement. We may share health information if a law enforcement official asks for it:
- to respond to a court order, warrant, summons or other similar process;
- to identify or locate a suspect, fugitive, material witness or missing person; or
- to obtain information about an actual or suspected victim of a crime.

We may share information with a law enforcement official:
- if we believe a death was the result of a crime;
- to report crimes on our property; or
- in an emergency.

Coroners, Medical Examiners and Funeral Directors. We may share health information with a coroner or medical examiner.
to identify a dead person or find the cause of death. We also may release health information to funeral directors if they need it to do their job.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to the organizations in charge of getting, transporting or transplanting an organ, eye or tissue.

To Prevent a Serious Threat to Safety. We may use and share your medical information to prevent a serious threat to your health and safety or the health and safety of others.

Special Governmental Functions. We may share your medical information with:

- Authorized federal officials
- for intelligence, counter-intelligence and other national security activities authorized by law; or
- to protect the president.

Armed forces command authorities or the Department of Veteran’s Affairs
- to see if you are fit for military duty or eligible for veterans health services; or
- to see if you are medically fit to receive a security clearance by the Department of State.

Correctional facility or law enforcement official or agency if you are an inmate or under the custody of a law enforcement official or agency, if necessary, to:
- help the correctional facility provide you with health care;
- or
- protect the health and safety of you and/or others.

Workers Compensation. We may share your health information with agencies or individuals to follow workers compensation laws or other similar programs.

WAYS WE MAY USE AND SHARE YOUR HEALTH INFORMATION WHEN WE HAVE GIVEN YOU A CHANCE TO OBJECT:

Individuals Involved in Your Care or Payment for Your Care. We may share medical information about you with your family members, friends or any other person you tell us is involved in your medical care or who helps pay for it.

We may tell your family or friends your condition and that you are in one of our facilities. We also may share medical information about you to a disaster relief agency so that your family can be told of your condition and location.

Usually you will have a chance to object to the sharing of this information.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

You have certain rights regarding your health information, described below. These rights apply to the health information we keep. You must submit a written request to use any of these rights. You can send your written request to the KPMC Privacy Officer at the address given at the end of this notice.

Right to Request Special Communications. You have the right to ask us to contact you about medical matters in a certain way or at a certain place. We will follow all reasonable requests. Your request must tell us how you wish to be contacted.

Right to Inspect and Copy. You have the right to read or get a copy of your health information, with some exceptions. We may turn down your request under certain circumstances. If we do so, you may ask for a licensed health-care professional chosen by us to review why we turned you down. We will follow the reviewer’s decision.

Right to Request Changes. If you believe the health information we created is wrong or incomplete, you may ask us to change it. You must provide a reason why you want the change. We cannot take out or destroy any information already in your medical record. We also are not required to agree to make the change. If we do not agree to the change, you can write a letter about the changes. We will send you one back saying why we will not make the changes. You may then send another disagreeing with us. It will be attached to the information you wanted changed or corrected.

Right to an Accounting of Disclosures. We are required to track who we share your health information with under certain circumstances. You have the right to ask for a copy of this list. We do not have to track every time we share your health information with others. Your request must give a time period, which may not be longer than 6 years and may not include dates before January 1, 2008.

Right to Request Restrictions. You have the right to ask for a restriction or limitation on the medical information we use or share about you for payment, treatment or health-care operations and the information we may share with your family, friends or others involved in your care. We are not required to agree to your request. If we agree, we will follow your request unless the information is needed to provide you with emergency treatment. You must tell us the type of restriction you want and to whom it applies.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. Copies of this notice will be posted and available at each location where medical services are provided.

OTHER USES AND SHARING OF YOUR HEALTH INFORMATION

All other uses and sharing of your health information will be done only with your written permission.

CHANGES TO THIS NOTICE.

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for your health information we already have as well as any we get in the future. The revised notice will be available at any of the locations where KPMC offers services.

WHAT IF I HAVE QUESTIONS OR NEED TO REPORT A PROBLEM?

If you have any questions about this notice or about how your health information is used or shared by us please contact the KPMC Privacy Officer by e-mail at admin@kpmconline.net or by calling 214-333-3393.

If you believe your privacy rights have been violated, you may file a complaint with us.

To file a complaint, please contact the KPMC Privacy Officer
2225 Vatican Lane
Dallas, Texas 75224
Please give as much information as possible so that the complaint can be looked into properly.

You may also file a complaint with the Secretary of the Department of Health and Human Services.

Your care will not be affected if you file a complaint, nor will any action be taken against you.
Patient Release of Medical Records Form  
(Please Print or Type)  

To:  

Name of Clinic/Physician  

Address  

Phone#  

Fax #  

Patient's Name:__________________________ request and give my permission to release my 
Medical Records for the time period dating from_________________ to _________________  

The Medical Records as listed above are to be released to:  

Dr. Louis Zegarelli  
4230 W Green Oaks Blvd  
Arlington, TX 76016  
817-200-7533  
Fax: 817-476-6051  

Printed Patient Name  

Date of Birth  

Social Security #  

Patient's Signature  

Today's Date
Motor Vehicle Accident Financial Information Form

Have you contacted a lawyer?  YES  NO  If yes, lawyer’s name _____________________________

Lawyer phone number ________________________________

Lawyer Address ________________________________

Do you have a Letter of Protection?  YES  NO

If yes, you must present a Letter of Protection during your first office visit.

Will your auto insurance be billed for this accident?  YES  NO

Have you filed a claim?  YES  NO

Name of Insurance Company ________________________________

Claim # ________________________________

Adjustor’s Name _________________________  Adjustor’s Phone Number _________________________

Is anyone else responsible for your charges?  YES  NO  If yes, whom?  __________________________

Address ________________________________  Phone # _________________________

Have you seen any other doctor, hospital, Emergency Room, Clinic, or other medical professional or facility in relation to this accident?  YES  NO

If YES, whom/where? ________________________________

Date(s) you were seen ________________________________