



Twisted Spine & Joint
— Dr. Bryan Stanton —

AUTO ACCIDENT QUESTIONNAIRE

General Information:

Name _____ Sex _____ Marital Status _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Home # _____ Work# _____ Cell# _____
Social Security # _____

Nature of Accident:

What was the date and time of this present injury? Date: _____ Time: _____ AM/PM

Please explain in detail how your accident happened. _____

Were you the _____ driver _____ passenger _____ back seat driver's side _____ back seat passenger side?

What direction was you headed? _____ North _____ south _____ east _____ west

What direction was the other vehicle headed? _____ North _____ south _____ east _____ west

Were you struck from _____ behind _____ front _____ left side _____ right side

Were you wearing a seat belt? ☒ YES ☐ NO

Did you come in contact with any objects in the car? ☒ YES ☐ NO

If yes, what? (i.e., windshield, steering wheel, etc.) _____

What parts of your body came in contact with the above object? _____

Were you unconscious as a result of the injury? ☒ YES ☐ NO

Were there any other passengers in the vehicle at the time of the accident? ☒ YES ☐ NO If yes, who and what are their ages and relationship to you? _____

Were the police called to the scene? ☒ YES ☐ NO Was an accident report taken? ☒ YES ☐ NO If yes, please provide a copy of the accident report for our files.

Were you taken to the hospital following the accident? ☒ YES ☐ NO By Ambulance? ☒ YES ☐ NO

Was any other doctor consulted after your accident? ☒ YES ☐ NO If yes, doctor's name? _____

Describe the doctor's diagnosis and treatment you received. _____

Are you still under a doctor's care: ☒ YES ☐ NO If yes, please explain. _____

Past History:

Have you ever injured this area before?: ☒ YES ☐ NO If yes, when? _____

Have you been involved in any previous accidents of any kind (personal injury, automobile accident, workers compensation)? ☒ YES ☐ NO If yes, please explain dates and details _____

Have you been treated previously by a Chiropractor? ☒ YES ☐ NO If yes, please explain _____

Have you enjoyed good health prior to this accident? ☒ YES ☐ NO If no, please explain (illness/injuries) _____

Present Information/Disability:

Have you returned to work? ☒ YES ☐ NO If yes, date you returned _____

Job description: _____

Are your work activities restricted due to this accident? ☒ YES ☐ NO If yes, explain _____

Do you notice any activity restrictions as a result of the injury? ☒ YES ☐ NO If yes, describe _____

Since this injury, are your symptoms _____ improving _____ getting worse _____ or the same? Explain: _____

Legal Representation:

Have you retained an attorney? ☒ YES ☐ NO If yes, give name, address and phone number _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I authorize the doctors at Twisted Spine & Joint to perform upon me diagnostic and/or therapeutic procedures arising from my current or presently unforeseen conditions, which the doctor may consider necessary or advisable in the course of my health.

Patient Signature

Date



9300 John Hickman Pkwy Ste 601
Frisco, Texas 75035-5897
ph. 469-678-0023

Financial Policies:

Updated: 01/01/2025

I agree to assign insurance benefits to **Twisted Spine & Joint**. We bill insurance companies as a courtesy for our patients and make every effort to inform patients of network status, however, patients are responsible for confirming with their insurance carrier if they deem our providers as in or out-of-network. I understand that if my contractual agreement with my insurance provider requires me to pay a copayment, deductible, and/or coinsurance, I must do so at the time of service to receive treatment.

I acknowledge full financial responsibility for services rendered by **Twisted Spine & Joint** and authorize transfer of all unpaid amounts to me, which includes, but is not limited to: co-pays, deductibles, co-insurance, pre-existing clauses, excluded conditions and/or termination of coverage. I agree to pay all legal fees, including attorney and court fee, as well as collection costs, in the event of default payment of charges that are my financial responsibility. I further authorize and request all insurance payments be made directly to **Twisted Spine & Joint** and authorize said assignee to release all information necessary, including medical records, to secure payment.

Changes in Insurance Coverage:

If you have a change in insurance coverage, it is your responsibility to make sure we have all of the pertinent information on file, including effective dates. Any medical expenses not covered by your insurance plan will be billed to you.

Return Checks:

A service charge of **\$30.00** will be added to all checks returned for non-sufficient funds. I agree to pay all legal fees, including attorney and court fees, as well as collection costs, in the event of default payment of charges that are my financial responsibility.

FMLA/Disability/Paperwork Policy:

Any FMLA, disability, or other paperwork requiring doctor review and completion is subject to a **\$125.00** fee. Please allow 2 weeks for this paperwork to be completed.

Cancellation Policy:

We require one business day's notice (24 hours) for cancellation of all doctor visits. Monday appointments must be cancelled on the preceding Friday. It is the policy of **Twisted Spine & Joint** to bill a cancellation fee to a patient that does not show or cancel at least one business day (24 hours) in advance of an appointment. This is to ensure that our treatment team is using their time to treat patients that are in need of our services. A patient that arrives 20 minutes past the time of the appointment may be considered a "no-show" for the purposes of this policy. A fee of **\$55.00** will be charged for no show/no call appointments.

I authorize **Twisted Spine & Joint** to contact me by automated SMS text message for appointment reminders. I understand that message/data rates may apply to messages sent by text under my cell phone plan. I may opt-out of receiving these communications at any time by calling **Twisted Spine & Joint**, or by responding **STOP** to the text message sent from **Twisted Spine & Joint**.

Please sign digitally by typing below indicating you have read, understand, and accept all policies.

Patient Name

Patient Signature

Date