ADVANCED INTEGRATED HEALTHCARE LLC
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advancemyhealth.com
An Integrated Approach to Wellness

PERSONAL INJURY QUESTIONNAIRE

PATIENT NAME: _____ **DATE:** _____

Where did the injury occur? _____ Date of injury: _____

The injury occurred: Indoors Outdoors Other_____

Please describe in your own words what happened during the injury.

_____

_____

_____

CONDITIONS AT TIME OF INJURY

Time of day: Full daylight Dusk Night

Conditions: Dry Damp Wet Snow-covered Ice-covered Patchy Ice/snow

Visibility: Excellent Good Fair Poor

Visibility compromised by: Brightness Darkness Rain Snow Fog Traffic

MOMENT OF IMPACT DURING THE INJURY

Did you lose consciousness? Yes No **Were you able to walk unaided?** Yes No

Immediately after the injury, did you feel? Dizzy Dazed Weak Nervous Disoriented Nauseated

Did you feel any numbness or tingling? Yes No If yes, describe where:_____

Were you:

☐Totally unaware that the injury was impending

☐Aware that the injury was impending

☐Aware that the injury was impending and braced for it

Where did you go?

☐Drove home ☐Drove to work ☐Was driven home ☐Was driven to work

☐Drove to hospital ☐Drove to school ☐Was driven to hospital ☐Was driven to school

☐Taken to hospital via ambulance

Hospital Name: _____Date of hospital visit: ____/____/_____

Were you admitted to the Hospital? Yes No

If you went to the hospital, what areas were x-rayed?

☐Head	Shoulder	☐Left	☐Right	Hip	☐Left	☐Right
☐Neck	Arm	☐Left	☐Right	Thigh	☐Left	☐Right
☐Upper back	Elbow	☐Left	☐Right	Knee	☐Left	☐Right
☐Mid back	Wrist	☐Left	☐Right	Calf	☐Left	☐Right
☐Ribs	Hand	☐Left	☐Right	Ankle	☐Left	☐Right
☐Chest	Fingers	☐Left	☐Right	Foot	☐Left	☐Right
☐Abdomen	Buttock	☐Left	☐Right	Toes	☐Left	☐Right
☐Low Back	☐Pelvis					

In what areas did you IMMEDIATELY feel pain?

□Head	Shoulder	□Left	□Right	Hip	□Left	□Right
□Neck	Arm	□Left	□Right	Thigh	□Left	□Right
□Upper back	Elbow	□Left	□Right	Knee	□Left	□Right
□Mid back	Wrist	□Left	□Right	Calf	□Left	□Right
□Ribs	Hand	□Left	□Right	Ankle	□Left	□Right
□Chest	Fingers	□Left	□Right	Foot	□Left	□Right
□Abdomen	Buttock	□Left	□Right	Toes	□Left	□Right
□Low Back	□Pelvis					

In what areas (if any) did you experience lacerations (cuts)?

□Head	Shoulder	□Left	□Right	Hip	□Left	□Right
□Neck	Arm	□Left	□Right	Thigh	□Left	□Right
□Upper back	Elbow	□Left	□Right	Knee	□Left	□Right
□Mid back	Wrist	□Left	□Right	Calf	□Left	□Right
□Ribs	Hand	□Left	□Right	Ankle	□Left	□Right
□Chest	Fingers	□Left	□Right	Foot	□Left	□Right
□Abdomen	Buttock	□Left	□Right	Toes	□Left	□Right
□Low Back	□Pelvis					

AFTER THE INJURY

On the next day, did your discomfort: increase remain the same decrease

Where did you experience pain on the day FOLLOWING the injury?

□Head	Shoulder	□Left	□Right	Hip	□Left	□Right
□Neck	Arm	□Left	□Right	Thigh	□Left	□Right
□Upper back	Elbow	□Left	□Right	Knee	□Left	□Right
□Mid back	Wrist	□Left	□Right	Calf	□Left	□Right
□Ribs	Hand	□Left	□Right	Ankle	□Left	□Right
□Chest	Fingers	□Left	□Right	Foot	□Left	□Right
□Abdomen	Buttock	□Left	□Right	Toes	□Left	□Right
□ Low Back	□Pelvis					

Did your major complaint exist before the injury? Yes No

As result of the injury, did you have to take time off from work or school? Yes No

If yes, please list dates missed: _____

Do you have an attorney? Yes No

Attorney Name: _____**Phone Number**: _____
Attorney Address: _____

Insurance Company Name: _____**Phone Number**: _____ **Claim #**: _____

Claims Address: _____**Contact Person:** _____

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

Doctor's Lien Agreement

Advanced Integrated Healthcare LLC
Dr. Bianca Kiovanni
325 Hammond Drive, Suite 201
Atlanta, GA 30328
(404)-256-0114 (404) 256-0167 Fax

Patient Name_____ Date of Occurrence_____

I am authorizing Dr. Bianca Kiovanni (hereafter referred to in this document as "the doctor") to furnish all my accident/injury treatment records, reports and billing information to my attorney or to a third party insurance company for liability case purposes.

I am authorizing my attorney to pay the doctor directly any and all monies due on my account in regards to said accident/injury. I direct my attorney withhold these amounts from any settlement due me to completely pay my account in full with the doctor. This is a notice of a lien on my case to this doctor against all monies awarded me, paid to my attorney or me in this accident/injury case.

I will notify the doctor within three business days of any changes in my legal representation. My attorney is instructed to make available a copy of this lien to any other legal counsel working on my behalf. I also realize the doctor may choose to make the full balance due if my legal counsel chooses not to sign this lien.

If I choose **not** to have legal representation, I agree that I am financially responsible in full to the doctor for any and all fees for treatment rendered to me by her or provided under her direction. I have been made aware that one itemized bill will be sent to the insurance company, and I agree to have Dr. Kiovanni reimbursed directly. I also understand that it is my responsibility to pay charges for services not covered by insurance, auto, or personal injury claim for which payment is denied or reduced through any adjuster, utilization review, or pre-certification procedures. The purpose of this lien is to protect the doctor in her consideration of rendering treatment ahead of payment. I further understand that my account will be sent to collections if no payments or arrangements have been made for any balances owing to Dr. Kiovanni/Advanced Integrated Healthcare 30 days **after** my case has been settled.

Patient Signature_____ Today's Date_____

By signing below, I state that I am the legal counsel representing the above signed patient; and I agree to comply with the terms as stated in the Lien Agreement above. If this lien becomes involved in litigation, I agree to award all attorney's fees and costs to the prevailing party.

Attorney Name (Print) _____

Address_____
_____

Attorney Signature_____ Date_____