AUTOMOBILE ACCIDENT QUESTIONNAIRE

PATIENT'S NAME: ______________________________________

TODAY'S DATE: _____________________ **DATE OF ACCIDENT:** ______________________________

NAME OF ATTORNEY/LAW FIRM: ____

THE FOLLOWING QUESTIONS PERTAIN TO YOU & THE INVOLVED IN THE ACCIDENT:

VEHICLE TYPE:

_____CAR _____PICKUP
_____VAN _____TRUCK
_____BUS _____STATION WAGON
_____OTHER_________________________

VEHICLE SIZE:

_____SUBCOMPACT _____FULL-SIZE
_____COMPACT _____MINIVAN
_____MID-SIZE _____LIGHT
_____HEAVY _____OTHER

YOUR POSITION IN THE VEHICLE:

_____DRIVER
_____PASSENGER, LOCATION: _____FRONT PASSENGER ___REAR PASSENGER _____THIRD ROW
_____LEFT _____MIDDLE ____RIGHT

SPEED OF YOUR VEHICLE:

_____STOPPED _____SLOWING
_____PARKED_____MOVING AT APPROX_____MPH

WHY VEHICLE WAS SLOWED OR STOPPED:

_____TRAFFIC LIGHT/STOP _____PARKING
_____PEDESTRIAN _____TRAFFIC
_____BUSY INTERSECTION

COLLISION TYPE:

_____DRIVER SIDE IMPACT _____HEAD ON COLLISION
_____PASSENGER SIDE IMPACT _____REAR IMPACT
_____FRONT IMPACT _____PEDESTRIAN INCIDENT

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

VEHICLE TYPE:

____CAR _____PICKUP
_____VAN _____TRUCK
_____BUS _____STATION WAGON
_____OTHER_________________________

VEHICLE SIZE:

_____SUBCOMPACT _____FULL-SIZE
_____COMPACT _____MINIVAN
_____MID-SIZE _____LIGHT
_____HEAVY _____OTHER

CONDITIONS AT THE TIME OF THE ACCIDENT:

TIME OF DAY:	ROAD CONDITIONS:	VISIBILITY:	VISIBILITY COMPROMISED BY:
_____FULL DAYLIGHT	_____DRY	_____EXCELLENT	_____BRIGHTNESS
_____DUSK/DAWN	_____DAMP	_____GOOD	_____DARKNESS
_____NIGHT	_____WET	_____FAIR	_____RAIN
	_____SNOW COVERED	_____POOR	_____SNOW
	_____ICE COVERED		_____FOG
	_____PATCHY/ICE/SNOW		_____TRAFFIC

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

WERE YOU?

_____TOTALY UNAWARE THAT THE ACCIDENT WAS IMPENDING

_____AWARE THAT THE ACCIDENT WAS IMPENDING

_____AWARE THAT THE ACCIDENT WAS IMPENDING AND BRACED FOR IT

RESTRAINTS (CHECK ALL THAT APPLY):

_____LAP BELT

_____SHOULDER HARNESS

_____NO RESTRAINTS

IF YOU WERE THE DRIVER OF THE VEHICLE, WAS YOUR FOOT ON THE BRAKE PEDAL?

_____YES _____NO _____KNOCKED OFF BY IMPACT

WAS THE AIRBAG DEPLOYED?

_____CAR NOT EQUIPPED WITH AIR BAG

_____AIRBAG DEPLOYED

_____AIRBAG NOT DEPLOYED

IN WHAT POSITION WAS YOUR HEADREST?

_____HIGH POSITION

_____MIDDLE POSITION

_____LOW POSITION

POSITION OF YOUR HEAD AT TIME OF IMPACT:

_____FACING STRAIGHT AHEAD

_____TILTED FORWARD

_____ROTATED TO THE LEFT

_____ROTATED TO THE RIGHT

WAS YOUR HEAD THROWN…?

_____BACKWARD THEN FORWARD

_____FORWARD THEN BACKWARD

_____TO THE LEFT _____TO THE LEFT THEN RIGHT

_____TO THE RIGHT _____TO THE RIGHT THEN LEFT

POSITION OF YOUR BODY AT THE TIME OF IMPACT:

_____STRAIGHT

_____TILTED FORWARD

_____ROTATED TO THE LEFT

_____ROTATED TO THE RIGHT

WAS YOUR BODY THROWN…?

_____BACKWARD THEN FORWARD

_____FORWARD THEN BACKWARD

_____TO THE LEFT _____TO THE LEFT THEN RIGHT

_____TO THE RIGHT _____TO THE RIGHT THEN LEFT

_____ACROSS THE VEHICLE _____UNDER THE VEHICLE

_____OUTSIDE VEHICLE

DAMAGES TO THE VEHICLE YOU WERE IN:

_____INCURRED MINIMAL DAMAGE

_____INCURRED MODERATE DAMAGE

_____INCURRED SEVERE DAMAGE

_____WAS TOTALED

_____NOT KNOWN

CITATIONS:

_____NONE ISSUED

_____YOURSELF

_____DRIVER OF VEHICLE YOU WERE IN

_____DRIVER OF THE OTHER VEHICLE

_____OTHER

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

HEAD

_____STEERING WHEEL

_____DASHBOARD

_____WINDSHIELD

_____ARM REST

_____HEAD REST

_____REARVIEW MIRROR

_____LEFT DOOR

_____CONSOLE

_____GEAR SHIFT

_____FRONT SEAT

_____BACK SEAT

RIGHT ARM

_____STEERING WHEEL

_____DASHBOARD

_____WINDSHIELD

_____ARM REST

_____HEAD REST

_____REARVIEW MIRROR

_____RIGHT WINDOW

_____CONSOLE

_____GEAR SHIFT

_____FRONT SEAT

_____BACK SEAT

LEFT LEG

_____STEERING WHEEL

_____DASHBOARD

_____WINDSHIELD

_____ARM REST

_____HEAD REST

_____REARVIEW MIRROR

_____RIGHT WINDOW

_____CONSOLE

_____GEAR SHIFT

_____FRONT SEAT

_____BACK SEAT

LEFT ARM

_____STEERING WHEEL

_____DASHBOARD

_____WINDSHIELD

_____ARM REST

_____HEAD REST

_____REARVIEW MIRROR

_____LEFT DOOR

_____RIGHT WINDOW

_____CONSOLE

_____GEAR SHIFT

_____FRONT SEAT

_____BACK SEAT

TORSO

_____STEERING WHEEL

_____DASHBOARD

_____WINDSHIELD

_____ARM REST

_____HEAD REST

_____REARVIEW MIRROR

_____LEFT DOOR

_____RIGHT WINDOW

_____CONSOLE

_____GEAR SHIFT

_____FRONT SEAT

_____BACK SEAT

RIGHT LEG

_____STEERING WHEEL

_____DASHBOARD

_____WINDSHIELD

_____ARM REST

_____HEAD REST

_____REARVIEW MIRROR

_____LEFT DOOR

_____RIGHT WINDOW

_____CONSOLE

_____GEAR SHIFT

_____FRONT SEAT

_____BACK SEAT

WERE YOU AT FAULT FOR THE ACCIDENT?

_____YES _____NO

THE FOLLOWING QUESITONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

DID YOU LOSE CONSCIOUSNESS? IMMEDIATELY FOLLOWING THE ACCIDENT, DID YOU FEEL?

_____YES

_____NO

_____DIZZY _____WEAK _____DAZED

_____NERVOUS _____DISORIENTED _____NAUSEATED

WERE YOU ABLE TO WALK UNAIDED?

_____YES

_____NO

WHERE DID YOU GO?

_____DROVE HOME

_____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

_____OTHER____

NEXT DAY DISCOMFORT:

_____ INCREASED

_____DECREASED

_____SAME

DID YOUR MAJOR COMPLAINTS EXIST BEFORE THE ACCIDENT?

_____YES _____NO

IN WHAT AREAS DID YOU IMMEDIATELY FEEL PAIN?

_____HEAD	SHOULDER:	____ LEFT	_____RIGHT	HIP:	_____ LEFT	____RIGHT
_____NECK	ARM:	_____ 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
_____LOWER BACK						
_____PELVIS						

IN WHAT AREAS 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
_____LOWER BACK						
_____PELVIS						

AT THE HOSPITAL, WHAT AREAS WERE RADIOGRAPHED?

_____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

_____LOWER BACK

_____PELVIS

WHERE DID YOU EXPERIENCE PAIN ON THE DAY FOLLOWING THE ACCIDENT?

_____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

_____LOWER BACK

_____PELVIS

ST LUKE'S REGIONAL HEALTHCARE, PLC
DR. JOSEPH B. GHALY, MD

6030 S FLORIDA AVENUE, SUITE 110 - LAKELAND, FLORIDA 33813
PHONE: (863) 644-9800 - FAX (863) 644-9822

IRREVOCABLE ASSIGNMENT OF BENEFITS

1. I hereby authorize St Luke's Regional Healthcare, PLC, and/or any medical services provider there including or without limitations, to bill my insurance company or companies directly for any services rendered to me for any insurance benefits otherwise available to me.

2. I hereby instruct and direct any insurance company or other collateral source for which I am entitled to benefits which should pay monies owed as a result of medical services rendered by St Luke's Regional Healthcare, PLC to make payment in the name of and directly to St Luke's Regional Healthcare, PLC.

3. I further instruct my insurance company to cooperate with the above-captioned healthcare provider in resolving all medical billing disputes. Cooperation includes but is not limited to providing all declaration pages, PIP Logs, payout ledgers, explanations of benefits, copies of checks, and any and all other documents or information to St Luke's Regional Healthcare, PLC or any attorney, employees, or other representative acting on behalf of St Luke's Regional Healthcare, PLC. I further direct and authorize you to speak to an attorney, employee, or any other representative of St Luke's Regional Healthcare, PLC or anyone acting on their behalf over the phone and provide them with any and all information you may have, or documentation not previously listed above that they may request

4. St Luke's Healthcare, PLC is authorized to file suit on my behalf against my insurance company that denies benefits for medical services rendered to me and to collect any damages awarded or settlement of monies for services rendered, plus interest, costs and reasonable attorney's fees. I understand that in any such lawsuit, my name or other identifying information will need to be included in and/or portions of my medical file attached to pleadings and/or formal discovery. I waive any confidentiality of my records and/or information to the extent necessary to prosecute a claim against the insurance company or any other responsible party.

These payment instructions are for the benefits payable to me under my current insurance policy as payment towards the total charges for professional services rendered. I, as the patient, have agreed to remain personally liable for the amounts billed by the healthcare provider regardless of the amount paid by the insurance company unless ordered otherwise by a court of law. I fully understand that said healthcare services are being provided to me in consideration for an unconditional promise to pay for me providing these instructions to my insurance company. I, as the patient, further agree to be liable for reasonable attorney's fees and costs incurred in collection of any delinquent accounts or unpaid balances.

By executing this document, I am placing my insurance company on notice that this is a direct assignment of benefits pursuant to Florida law. As the insured or beneficiary of said insurance policy, I am irrevocably assigning whatever rights I have under my policy of insurance and under Florida law to this healthcare provider. A photocopy of these instructions shall be considered as effective and valid as the original.

______________________________	______________	________________________
Patient Signature	Date	Acceptance of Provider

Revised 4/05/23 (LG)

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

____

____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

______________________	______________________	______________
Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her* ***own hand****)*:

______________________	______________________	______________
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

Joseph Ghaly, MD

Date:___________________________

I am a physician licensed in Florida under Florida Statute (hereinafter "F.S") 458 or 459 or an advanced registered nurse practitioner licensed under F.S. 464. Or a physician assistant licensed under F.S. 456.

I examined patient_______________________________ with a date of birth of_____________________ and determined that he/she has an emergency medical condition.

An emergency medical condition is defined pursuant to Florida Statute 627.736 as "a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to patient health, and/or serious impairment to bodily functions, and/or serious dysfunction of any bodily organ or part."

Practitioner Name: _____ Youssef B Ghaly, MD

_____ Ashley Williams, PA-C

_____ Tia Flowers, PA-C

Practitioner Signature: _________________________________

Date of Accident: ____________________________

Claim No: __________________________________

6030 S Florida Ave, Suite 110
Lakeland, Florida 33813
Phone: 863-644-9800
Fax: 863-644-9822
Website: www.stlukesfl.com

Revised 4/05/2023 (YA)