HEALTHSOUTH®

Accident Questionnaire

If at any time the patient should answer "YES" to the accident question on the Patient's Pre-Assessment and/or Insurance Verification Form, please continue with the following questions.

1. **Patient name** _____
2. **Patient account #**_____ **Medical record #**_____
3. **What was the date of accident/injury?** _____
4. **Where did accident/injury occur?** _____
5. **What type of accident/injury was this?** _____

   a) **If motor vehicle (MVA)**

      i. Was a police report filed? ☐ Yes ☐ No

         1. If yes, how can we obtain a copy of police report (case number, precinct, officer name etc)?

            _____

         2. Was this MVA patient's responsibility or other party? _____
         3. Based upon determination of fault, is patient's auto liability or other party's auto liability policy covering damages (unless No-fault state)?

            _____

         4. Name and telephone information of auto insurance handling auto liability coverage (patient and other parties)

            _____

            _____

         5. Will there be a lawsuit filed in court? If yes, see #c) ☐ Yes ☐ No
         6. Has patient contacted an attorney? ☐ Yes ☐ No

   b) **If not MVA, where did accident occur?** _____

      i. If on city or another party's property:

         1. Was a police report filed? ☐ Yes ☐ No
         2. If yes, how can we obtain a copy of police report (case number, precinct, officer name, etc)?

            _____

         3. Is the patient filing a lawsuit against city or other party? ☐ Yes ☐ No
         4. Is other party's homeowners policy and/or liability insurance involved in payment of medical expenses? ☐ Yes ☐ No

5. Get name and telephone information of liability insurance. Company/agent handling case.

_____

6. Has patient contacted an attorney? ☐ Yes ☐ No (If yes, see #C)

ii. If accident happened on patient's own property:

1. Will patient be filing against homeowner's policy? ☐ Yes ☐ No
2. Get name and telephone information of homeowner's insurance agent.

_____

3. Will there be a lawsuit filed against a vendor? If yes, see #c) ☐ Yes ☐ No
4. Has patient contacted an attorney? ☐ Yes ☐ No (If yes, see #C)

c) **If patient answers "Yes" to a lawsuit filed in court**

1. Get name and telephone number of lawyer handling suit.

_____

2. Who is the suit against? _____

6. Workers Compensation ONLY -

If the patient answered YES to the W/C question on the Insurance Verification Form, please continue with the following questions. Please ensure that the employer information is completed on the Insurance Verification Form

a) If illness/injury was work related was a report filed with the employer? ☐ Yes ☐ No

b) Does the patient expect to receive or have they received W/C benefits? ☐ Yes ☐ No

Comments: _____

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Information taken by: _____ Date/Time: _____