CenterPoint Chiropractic

Auto Related Accident Form

Patient's Name: _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____ ☐ a.m. ☐ p.m.

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger

If a traffic violation was issued, to whom was it issued? _____

Number of people in accident vehicle: _____

Did the police come to the accident site? ☐ Yes ☐ No

Was a report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Were you wearing your seat belt? ☐ Yes ☐ No

Was this vehicle equipped with airbags? ☐ Yes ☐ No If yes, did they inflate? ☐ Yes ☐ No

In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At base of skull

What did your vehicle impact? ☐ Another vehicle ☐ Other _____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No If Yes, please describe: _____

_____

Make & model of the vehicle you were occupying: _____

Name of the location/street on which you were traveling: _____

In which direction where you headed? ☐ N ☐ S ☐ E ☐ W

What was the approximate speed of your vehicle? _____ mph

Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐ Right ☐ Left ☐ Other

During impact, were you facing? ☐ Right ☐ Left ☐ Forward

Were you aware or surprised by the impact? ☐ aware ☐ surprised

In your words, please describe the accident: _____

_____

_____

If accident vehicle made impact with another vehicle…

Make & mode of that other vehicle: _____

Direction other vehicle was heading: ☐ N ☐ S ☐ E ☐ W Speed of other vehicle:_____ mph ☐ Unknown

Did accident render you unconscious? ☐ Yes ☐ No If Yes, for how long? _____

Please describe how you felt immediately after the incident:

_____

Have you gone to a hospital or seen any other Doctor? ☐ Yes ☐ No

When did you go? ☐ Just after accident ☐ Next day ☐ Two days or longer

How did you get there? ☐ Ambulance ☐ Private Transportation

Name of hospital and/or attending doctor: _____

Was he/she a: ☐ D.C. ☐ M.D./D.O. ☐ Unknown ☐ Other: _____

Describe any treatment you received: _____

_____

Were x-rays taken? ☐ Yes ☐ No

Was medication prescribed? ☐ Yes ☐ No

Have you been able to work since this injury? ☐ Yes ☐ No

Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes & Goes

Indicate the symptoms that are a result of this accident? Check all that apply.

☐ Dizziness ☐ Difficulty Sleeping ☐ Jaw Problems ☐ Nausea ☐ Memory Loss ☐ Irritability ☐ Arms/Shoulder Pain ☐ Back Pain

☐ Headache(s) ☐ Low Back Pain ☐ Numb Hands/Fingers ☐ Fatigue ☐ Blurred Vision ☐ Tension ☐ Back Stiffness ☐ Chest Pain

☐ Buzzing in the Ear ☐ Neck Pain ☐ Shortness of Breath ☐ Leg Pain ☐ Ears Ringing ☐ Numb Feet/Toes ☐ Stomach Upset

☐ Neck Stiffness ☐ Other: _____

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on Back	☐	☐	☐
Lying on Side	☐	☐	☐
Lying on Stomach	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Lovemaking	☐	☐	☐
Walking	☐	☐	☐
Lifting	☐	☐	☐
Bending	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐

Recovery

To evaluate the effect that continuing to work will have on your recovery, please complete the following:

How many hours are in your normal workday? _____

Please indicate your daily job duties and any activities which you are occasionally asked to perform.

☐ Standing ☐ Driving ☐ Operation of Equipment ☐ Sitting ☐ Twisting ☐ Work with arms above head ☐ Walking ☐ Crawling ☐ Typing ☐ Lifting ☐ Bending

☐ Stooping ☐ Other: _____

What positions can you work in with minimal physical effort and for how long? _____ ☐ N/A

Prior to the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Do you work with others who can help you with any heavy lifting? ☐ Yes ☐ No ☐ N/A

While in recovery, is there any light duty work you could request? ☐ Yes ☐ No ☐ N/A

Attorney Information

Name of Attorney: _____

Address of Attorney: _____

Phone Number of Attorney: _____

Patient's Vehicle Insurance Information

Ins. Company Name: _____

Agents Name: _____

Name on Policy: _____

Policy #: _____ Claim # _____

Medical Pay Coverage: _____

Responsible Party's Vehicle Insurance Information

Ins. Company Name: _____

Address: _____

Phone Number: _____

Name on Policy: _____

Policy #: _____ Claim # _____

Primary Health Insurance

Ins. Company Name: _____

Address: _____

Phone #: _____

Insured's Name: _____ DOB: _____

Policy #: _____ Group # _____

Insured's Employer: _____

Additional Insurance Secondary Health Insurance, Second Insurance Source, or Additional Auto Insurance

Type of insurance: _____

Co. Name: _____

Address: _____

Phone #: _____

Insured's name: _____

Policy #: _____ Claim # _____

Insured's Employer: _____

Agents Name: _____

Please notify your auto insurance carrier of your visit to our office immediately. We will submit to your medical payments if applicable. We collect 100% of our fees for personal injury or automobile accidents. Notify our insurance department immediately if an attorney is representing you. Although you are ultimately responsible for your bill, it is our office policy to allow 90 days after you have been dismissed from care for the claim to be settled with the liability company. Once the 90 days is reached, if no settlement has been made, we require the patient to start making payments towards their personal injury case in order to avoid further action/collections. If any of your medical or account information has changed, please inform our front desk personnel. Please remember you are ultimately responsible for your account.

Print Patient Name _____ Date: _____

Patient/Responsible Party Signature _____

CenterPoint
chiropractic, acupuncture and nutrition

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION ("AGREEMENT")

I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or to other legal entities ("payers"), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past or future ("condition"), to pay directly to, and exclusively in the name of, CenterPoint Chiropractic such sums as may be owing to CenterPoint Chiropractic for charges incurred by me, including but not limited to, charge for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at this office. I further grant a contractual lien to CenterPoint Chiropractic with respect to my charges, applicable to all payers, however, I understand that nothing in this Agreement shall be construed as an election by CenterPoint Chiropractic to claim protection under any statutory lien law. For the purpose of this Agreement, "benefits" shall include, but shall not be limited to, proceeds from settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payee is benefits, personal injury protection, lost wages benefits, lost service benefits, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purposes stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay CenterPoint Chiropractic, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to CenterPoint Chiropractic to extent of my charges, as well as any and all causes of action that I might have against such payer, to prosecute such causes of action either in my name or in the Office's name, and to settle or to otherwise resolve such causes, of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issuer a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office. I further direct each attorney to provide immediate notice to this Office regarding any funds received by the attorney relating to my accident, to promptly pay such Office, and to provide a full accounting of such funds to this Office upon its request.

I hereby direct all payers to release to CenterPoint Chiropractic any information regarding any coverage or benefits which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize CenterPoint Chiropractic to endorse/sign my name on any and all checks listing me as a payee, which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize CenterPoint Chiropractic to apply any credit balance on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due to CenterPoint Chiropractic for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect any outstanding balance on my account, I will be responsible for payment and will reimburse CenterPoint Chiropractic for all cost of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual consent of CenterPoint Chiropractic and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interest of CenterPoint Chiropractic and myself. However, should any provisions of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, neverless, remain in full force and effect.

Patient Name (please print)_____

Patient/ Signature_____ Date:_____

Name of Custodial Parent or Legal Guardian (please print) _____

Parent/Guardian Signature_____ Date:_____

Financial Policy, Patient Bill of Rights and Responsibilities

Thank you for choosing CenterPoint Chiropractic as your healthcare provider. We are committed to providing excellent healthcare services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy. All patients must read and sign this form prior to receiving services. It is your responsibility to provide us with your most current insurance information.

1. If you do not have health insurance, or your health insurance does not have chiropractic benefits, you are financially responsible for the full amount of services rendered.

2. We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company, and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.

3. If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for the full amount of services rendered.

4. Please be aware that some or perhaps all of the services may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.

5. Before receiving services, you should verify that we are participating providers for your insurance company. It is also necessary that if you are a participant in an HMO plan you must obtain an insurance referral from your primary care physician listed on your insurance card before you are seen by another healthcare provider.

6. Co-payments must be collected at the time of service. This is a requirement set by your insurance company. No exceptions.

7. You must provide your most current billing address, all available telephone numbers and any other important contact information and if any of this changes, it is your responsibility to contact us with the updated information.

8. Interest and/or finance fees may be added to any outstanding balance not paid within 20 days of receipt of the first statement.

9. Personal Injury or Automobile Accidents: It is our office policy to allow 90 days after you have been dismissed from care for the claim to be settled with the liability company. Once the 90 days is reached, if no settlement has been made, we require the patient to start making payments towards their personal injury case.

By signing below you acknowledge that you have read the Financial Policy and fully understand its terms.

Print Patient Name _____ Date: _____

Patient/Responsible Party Signature _____