WRIGHT CHIROPRACTIC AUTO INJURY FORM

PLEASE PROVIDE A COPY OF THE ACCIDENT REPORT OR HAVE YOUR ATTORNEY PROVIDE IT.

NAME_____ DATE_____

Date of Accident_____ Time: ___am ___pm Location of Accident_____

AUTO INJURY

Were You: ( ) Driver ( ) Passenger ( ) Pedestrian

Were you struck from: ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked

Did your car strike the others involved: ( ) Yes ( ) No ( ) Undetermined

Did the other car strike yours: ( ) Yes ( ) No ( ) Undetermined

Did your car end up : upright on side flipped onto roof

Was it spun around: none <90 degrees 90 180 360

As a result of the Accident, were traffic citations issued to you? ( ) Yes ( ) No

What type of vehicle were you driving?_____

What type of vehicle was the other person(s) driving?_____

How fast were you going?_____mph or stopped Other person?_____mph or stopped

Did You Have your seatbelt on? Y N Did your airbags deploy? Y N

Did you see the accident coming? Y N

Describe the circumstances of the accident (Be Specific)_____

_____

_____

_____

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CHECK SYMPTOMS YOU HAVE NOTED SINCE THE ACCIDENT

( ) Headache
( ) Neck Pain
( ) Neck Stiff
( ) Dizziness
( ) Back Pain
( ) Nervousness
( ) Tension
( ) Irritability
( ) Chest Pain
( ) Sleeping Problems
( ) Head Too Heavy
( ) Pins & Needles in Arms
( ) Pins & Needles in Legs
( ) Numbness in Fingers
( ) Numbness in Toes
( ) Shortness of Breath
( ) Fatigue
( ) Depression
( ) Lights Bother Eyes
( ) Loss of Memory
( ) Ears Ringing
( ) Face Flushed
( ) Buzzing in Ears
( ) Loss of Balance
( ) Fainting
( ) Loss of Smell
( ) Loss of Taste
( ) Diarrhea
( ) Feet Cold
( ) Hands Cold
( ) Stomach Upset
( ) Constipation
( ) Cold Sweats
( ) Fever
( ) Other

Did you go to the hospital: on own in ambulance via careflight didn't go

Did you require post-accident hospitalization? ( ) Yes ( ) No

Have you lost any days of work? ( ) Yes ( ) No If Yes, _____ through _____

INSURANCE INFORMATION

Your Insurance Co _____Phone:___|_____

Address_____

Other Party's Name_____Address_____

Other Party's Ins. Co._____Address_____

Have you been contacted by an adjustor regarding this claim ( ) Yes ( ) No CLAIM #_____

If yes, name of adjuster_____Company_____

Do you have an attorney that has advised you in this case: ( ) Yes ( ) No

If yes, attorney's name_____Address_____

Signature_____

PI Financial Payment Agreement

I, _____ as the patient (parent/guardian of patient _____), am willingly entering a financial payment agreement with Wright Chiropractic Health Center. I understand that payment for services and products is ultimately my responsibility regardless of the outcome of the case.

I understand there is several avenues in which Wright Chiropractic Health Center will pursue for reimbursement, including use of Personal Injury protection of the responsible party's auto insurance, use of PIP on my auto insurance, payments by myself, my health insurance, and the final settlement if applicable.

If I have PIP (personal injury protection) coverage on my auto insurance or through another party's PIP, I understand that I am responsible for completing all paperwork necessary to start and carry out the PIP coverage in a timely manner. I understand that if I do not activate my PIP coverage, Wright Chiropractic Health Center will be unable to continue the doctor/patient relationship, and I will be responsible for seeking a new provider for this case.

If I have no PIP coverage on my auto insurance, I understand that Wright Chiropractic Health Center will require regular payments of $15 a visit and will wait for up to 1 month after the abovementioned patients' release date for a settlement to be reached. After that one month period is over, payments of at least $75 will become due and will be my responsibility to regularly make each month by the 10th of the month until settlement is reached.

At the time of settlement I understand that the account will be adjusted for any payments that I have made such that I will be reimbursed by Wright Chiropractic out of the settlement.

Financial or interest fees that accrue are solely my responsibility, will be deducted from my reimbursement, and can be avoided by making timely payments as outlined in this document.

Payments will be at least $75 each month, due on the 10th of the month. If mailed, they must arrive at Wright Chiropractic Health Center by the 10th of the month.

I understand that a late fee of $25 will be added to my bill if I am late making payment. If I default by failing to make 2 payments in a row, then a finance charge of 18% APR cumulative will be charged to any outstanding balance in addition to the late fees up until regular payments are resumed.

I understand that I will be responsible for all collection fees and charges associated with my account including any court fees that may result from recovery of my account should it become delinquent.

As it is the policy of this office to have this form on file, I understand that failure to sign this form may result in Dr. Wright choosing not to accept me as a patient.

_____ _____ _____ _____

Patient/Guardian Date Witness Date

Non-Rescindable Agreement Letter

This agreement is between _____ _____-and Dr. Heather Wright,
and any third-party involved in the accident on _____.
I, _____do hereby authorize and agree to pay any outstanding balance due on my account at the time of my release from care.

I instruct any monies due from my personal injury protection to be paid directly to my physician.

I instruct my attorney to pay in full any outstanding monies due my physician at the time of settlement with any liability claims that result from this case. My attorney shall not withhold any portion of the amount due to my doctor under this agreement to offset attorney's fees, which my attorney now or hereafter may claim to be owed by me. I instruct my attorney to pay my doctor immediately upon settlement, by way of issuance of a separate draft made payable to the physician/clinic.

I instruct any third-party individual or insurance carrier that may be liable, to pay my physician direct for any outstanding medical bills which are the result of this accident. If payment is not made until time of settlement, I instruct the third party to issue a separate draft to be payable to the physician/clinic for the medical bills.

I understand and acknowledge that all charges incurred by me are my responsibility regardless of any settlement made by a third party. I am instructing and agreeing to the above conditions as a safeguard to the physician's right to collect payment. I understand that the physician/clinic has the right to expect good faith payments on my account and that a full payment is being deferred only until such time as a third party settlement occurs. If a settlement does not occur within a reasonable amount of time, I agree to make other arrangements to pay my account in full.

I understand that I must make weekly payments of **$50** to Wright Chiropractic Health Center due on__ **Monday** of each week until settlement is made and dispersed. Upon settlement, the balance is due immediately, and I am responsible for payment to Wright Chiropractic Health Center for my balance in full. I understand that I am completely responsible for my balance, regardless of outcome of settlement or litigation.

_____ _____ _____ _____
Patient's /Guardian's Signature Date Witness Date

Exit Financial :

I understand that I have been released from care and must continue to make weekly payments in the amount of $_____ until settlement is reached. Once settlement is reached, I agree to pay balance in full to Wright Chiropractic Health Center. All of the above conditions and agreements still stand.

I understand that I am completely responsible for my balance, regardless of outcome of settlement or litigation.

_____ _____ _____ _____
Patient's /Guardian's Signature Date Witness Date

AUTHORIZATION AND ASSIGNMENT

Dr. Heather Wright, DC/ Wright Chiropractic Health Center

In consideration of your undertaking to treat me, I agree to the following:

Authorization to Release Information

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges occurred by me as a result of professional services rendered by Wright Chiropractic Health Center, and I hereby release you of any consequences thereof.

Assignment of Cause of Action

In the event any insurance company is obligated by contractual agreement to make payment to me or to you I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name or your name. I further authorize you to consent, settle or otherwise resolve claim as you see fit. I understand that whatever amounts you do not collect from the insurance company (whether it is all or part of what is due), I personally owe you and agree to fully reimburse the balance.

Authorization to Pay Directly to the Doctor

In consideration of the professional services rendered and to be rendered by Dr. Heather Wright, DC, I authorize and direct the payment to the doctor named above of any sum I now or hereafter owe her by the insurance company or attorney.

_____ _____ _____ _____

Patient Signature Date Witness Date