

HealthQuest Chiropractic, P.C.

Jaren L. Sayer, D.C., C.C.E.P.

AUTOMOBILE ACCIDENT HISTORY

Insurance Company _____ Policy Number _____

Address: _____ Name of Agent _____

(Circle all that apply)

Have you retained an attorney? **Yes No**

Name and Address of Attorney: _____

General Symptoms:

Did you hit part of your body during the collision, for example: head on dash, chest on steering wheel? **Yes No**

If yes, which part and how? _____

Where were you taken after the accident? _____

Were you hospitalized? **Yes No** If yes, for how long? _____

Accident History:

Date of Accident: _____ Time of Accident: _____ A.M. P.M.

State how the Accident happened in your own words:

What type of vehicle were you in? Make: _____ Year: _____

Were you driving? **Yes No** Was it your car? **Yes No** If not, whose? _____

Passenger? **Front Back Right Side Left Side** Were you rotated in seat? **Yes No**

Were you reclined? **Yes No** Other: _____

Other people in car? **Yes No** _____

Names and Addresses:

Were they injured? **Yes No**

If yes, please explain: _____

Seat belts on? **Yes No** Shoulder harness on? **Yes No** Position of headrest _____

Was it? **Daylight Night Dark Dawn** What were the weather conditions? _____

How long had you been in the car? _____ What were you doing prior to the Accident? _____

What were the traffic conditions? _____ What was the posted speed limit? _____

How fast were you going? _____ Type of road: **2 Lane** **4 Lane** **Gravel** **Tar**

Did it happen at a/an: **Stop Sign** **Traffic Light** **Intersection** **Highway**

Was your car hit? **Front** **Back** **Left Side** **Right Side**

What damage was done to your car?

Inside: _____

Outside: _____

Other: _____

If you struck another car, did you strike it: **Front** **Back** **Side**

What was the damage to the other car?

Inside: _____

Outside: _____

In what condition was the vehicle prior to the Accident? _____

Do you have pictures of the involved automobile? **Yes** **No**

What type of vehicle was involved in the accident?

Car **Truck** **Motorcycle** **SUV** **Other:** _____ **Size and Type:** _____

Was accident report made? **Yes** **No** Police of: **City:** _____ **County:** _____ **State:** _____

Who was ticketed? _____ For what? _____

Did your vehicle strike anything? **Yes** **No** If yes: **Another Car** **Sign** **Tree**

Other: _____ **Size and Type:** _____

Were you completely conscious after the impact? **Yes** **No** Do you remember the impact? **Yes** **No**

Did your vehicle go off the road? **Yes** **No**

State any strange events that happened during or immediately after the Accident:

Have you had any time loss from work? **Yes** **No** If yes, from _____ to _____

Have you ever had to have any outside help? **Yes** **No** What type? _____

The above information is accurate and has been completed to the best of my knowledge:

Patient Signature: _____

Date: _____

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ASSIGNMENT

I was involved in an accident on or around _____ (date) in which I was injured for which I have or may have a claim against another person(s) for causing my injuries (including _____) (referenced as "My Claim"), who is insured by _____
(Name of Person at Fault)

In consideration of the agreement of **HealthQuest Chiropractic, P.C.** to delay billing me personally for medical treatment rendered until resolution of My Claim:

1. I now assign, without any right to later revoke, a part of any proceeds from my claim equal to the fees incurred by me to this Clinic for all treatment and other services rendered by this Clinic. I am not assigning any legal cause of action in My Claim above, but only prospective proceeds. I also assign to the Clinic my right to enforce the obligation of any insurance company to pay settlement proceeds for **any** settlement agreement made by or for me in exchange for my signing such insurance company's release of claim. Prior to settlement or other disposition of My Claim, I understand and permit Clinic to pursue payment from any other source but me personally, including medical payments coverage in an automobile liability policy.
2. This Assignment and related documents which I have signed in connection with it states the entire agreement and my complete understanding regarding the Clinic's fees. I have not relied on any statements by the Clinic or the Doctor or other information before making this Assignment. I understand that I remain responsible for any Clinic fees not paid out of My Claim.
3. I understand that it is my responsibility during treatment to remain aware of my cumulative account balance for services rendered. I have received a schedule of treatment fees for this Clinic, or if I have not, will request this Clinic for one in writing.
4. I understand that this is an express contract to pay for the services rendered by this Clinic. I agree to pay my account balance in full and/or direct its payment from My Claim proceeds regardless of whether any other person or entity attempts to or fails to fully reimburse me for it. If I dispute my account balance or treatment rendered, I agree that my remedy will be to resolve it with a separate action from My Claim.
5. NOTICE: I DIRECT ANY INSURANCE COMPANY, ATTORNEY, OR OTHER PERSON WHO HOLDS OR LATER HOLDS ANY PROCEEDS FROM MY CLAIM TO APPLY ANY PROCEEDS FROM MY CLAIM TO MY TOTAL ACCOUNT BALANCE OUT OF THE TOTAL PROCEEDS HELD IN MY BEHALF, UNLESS THE CLINIC CONFIRMS PRIOR PAYMENT OF IT IN WRITING. "TOTAL PROCEEDS" HELD BY AN ATTORNEY FOR MY CLAIM SHALL MEAN PROCEEDS AFTER DEDUCTION OF ATTORNEY FEES.
6. Idaho law governs this Assignment. Jurisdiction shall be in Idaho, and venue shall lie in the county in which the Clinic is located, unless required by applicable law to lie in a different county in which I reside.
7. I REALIZE THAT I HAVE NOW GIVEN AWAY A PART OF ANY PROCEEDS FROM MY CLAIM. IF I RECEIVE ANY PROCEEDS FROM MY CLAIM, I AGREE TO IMMEDIATELY DETERMINE IF THIS CLINIC HAS BEEN SEPARATELY PAID IN FULL. UNLESS THE CLINIC CONFIRMS FULL PAYMENT IN WRITING, I REALIZE THAT ANY USE BY ME OF THESE PROCEEDS IS TAKING OR CONVERTING MONEY THAT IS THE PROPERTY OF THIS CLINIC.
8. I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND IT.

(SIGNATURE OF PATIENT)

(DATE)

(PRINT OR TYPE PATIENT NAME)

This Assignment has been signed on the Clinic Premises:

(SIGNATURE OF PARENT OR LEGAL GUARDIAN)

(STAFF WITNESS)