REQUEST FOR ASSIGNMENT OF MEDICAL BENEFITS TO HEALTH CARE PROVIDER

Name of Patient: _____

Name of Insured (if different from patient):

_____

Insurance Company: _____

Healthcare Provider: _____

I am entitled to medical benefits under a policy of insurance written by the above insurance company. I have received treatment for an injury from the above health care provider.

As allowed by T.C.A. §56-7-120, I hereby assign to the above health care provider, from the medical benefits to which I am entitled, a sum of money sufficient to cover the charges of that health care provider for the services I have received. I hereby request that the above insurance company pay that money directly to the health care provider.

I understand that the amount which is paid to the above health care provider may be limited by the amounts owed to other health care providers who have provided services to me for the same injury and by the amount of medical benefits to which I am entitled under the policy.

If the above insurance company does not permit the assignment of benefits, I hereby request that the company disburse the medical benefit sums to which I am entitled in the form of a check issued in the names of the insured and the above health care provider as joint payees and sent to the office of the provider.

I understand that if the medical benefits available to me under the policy are insufficient to cover the charges of the above health care provider, I am responsible for paying that portion of the provider's charges not covered by insurance.

Patient Signature: _____ Date: _____

AUTO ACCIDENT: ADDITIONAL INFORMATION FORM

RESPONSIBLE PARTY INFORMATION
(PERSONAL INJURY COVERAGE)

Responsible Party's Name: _____
Insurance Company: _____
Claim Number: _____
Name of adjustor handling claim: _____
Phone Number: _____
Fax Number: _____

ACCIDENT INFORMATION:

Date of Accident: _____ Time: _____
Where did accident occur? City/Town: _____
What type of vehicle were you in? _____
Police Report Filed? □ Yes □ No
Were you: □ Driver □ Passenger □ Front Seat □ Back Seat
Were you wearing seatbelt? □ Yes □ No
What directions were you headed: □ North □ South □ East □ West
What direction was the other vehicle headed: □ North □ South □ East □ West
Were you struck from: □ Front □ Behind □ Left □ Right
What was the approximate speed at the time of impact?
Your vehicle: ____ mph Other vehicle: ____ mph
What was the weather at the time of the collision? □ wet □ dry □ icy
Were you knocked unconscious? □ Yes □ No If yes, for how long: _____

In your own words, please describe the accident:

_____
_____
_____
_____

Did you have any physical complaints BEFORE THE ACCIDENT? ☐ Yes ☐ No
If yes, please describe: _____

_____

Please describe how you felt:

A. DURING the accident: _____
B. IMMEDIATELY AFTER the accident: _____
C. LATER THAT DAY: _____
D. THE NEXT DAY: _____

Do you have any previous illness which relate to this case? ☐ Yes ☐ No
If yes, please describe: _____

_____

Were you taken to the hospital after the accident? If so, please answer the following:
Name of Hospital _____
Name of Doctor _____
Diagnosis _____
Treatment Received _____
Have you had X-rays/MRIs since the accident? ☐ Yes ☐ No
Have you lost time from work due to of this accident? ☐ Yes ☐ No
If yes, please complete following:
Last Day Worked: _____ Type of Employment: _____

PERSONAL INJURY PAYMENT POLICY

Scott Chiropractic and Wellness will occasionally accept patients who have been injured in a motor vehicle accident or other liability injury; however the decision is up to the provider whether or not to see an injured patient. There is no guarantee for payment even if the injury is covered under a first-party payer. Scott Chiropractic and Wellness has the right to be reimbursed for any medical benefits from the proceeds of any personal injury policy (PIP). The patient is ultimately responsible for all balances owed on their account. While we do not wish to do so, failure to pay or agree to a payment plan within 60 days of the above statement will result in your account being placed with a collections company.

Patient Signature: _____ Date: _____

REASON FOR VISIT

Patient Name: _____

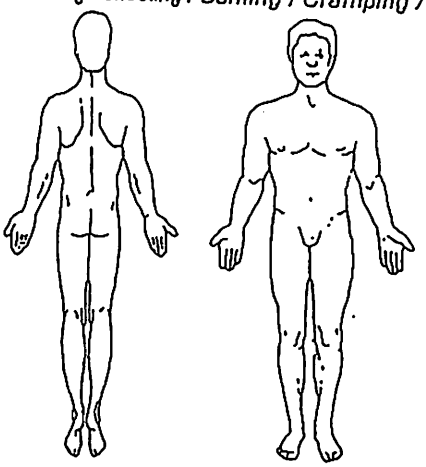
What is the reason for your visit today? ☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain ☐Other _____

What caused this complaint(s)? _____

When did this complaint begin? ___/ ___/___ Is it getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Have you had this or similar complaint in the past? ☐ Yes ☐ No If "Yes", when? _____

What does your complaint (s) feel like? Circle all that apply: *Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other* _____



←Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.

Area for doctor's notes:

On the scale below, please circle the severity of your main complaint right now:

No Pain					*Moderate Pain*					*Worst Possible Pain*
0	1	2	3	4	5	6	7	8	9	10

What area(s) does the pain radiate, shoot, or travel to? (If applicable)? _____

What aggravates this complaint? Circle all that apply: Sitting / Standing / Walking / Getting up from seat / Walking stairs / Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending forward / Bending backward / Twisting / Reaching / Lifting / Desk work / Sneezing / Coughing / Everything / Unknown / Other: _____

What relieves this complaint? Circle all that apply: Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching / Massage / Chiropractic / Heat / Ice / Laying down / Medication / Nothing / Unknown / Other: _____

How often do you experience your symptoms? ☐ 25% of the day ☐ 50% of the day ☐ 75% of the day ☐ 100% of the day

Timing of complaint: Check appropriate box: ☐ Morning ☐ As day progresses ☐ Afternoon ☐ Evening ☐ While sleeping ☐ During activities ☐ After activities ☐ Symptoms are constant and do not change ☐ Other: _____

With time are your symptoms: ☐ Improving ☐ Worsening ☐ Not changing

Have you seen other doctors for this complaint? ☐ Yes ☐ No If "Yes", please provide the following information:

Doctor's name: _____ Date consulted: _____ Diagnosis _____

Is this condition interfering with your (Circle all that apply) Sleep / Getting in or out of bed or chair / Personal care / Travel / Work / Recreation / Lifting / Walking / Standing / Daily Routine / Social Activities / Exercise / Other: _____

Is your complaint interfering with your daily activities? ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Name of person responsible for this account: _____

X _____ Date: _____

Signature of Patient, Parent or Legal Guardian (if minor)