ACCIDENT HISTORY

Date of Accident ___/___/___ Patient_____

Injury: Auto Work Comp Other_____

Location of Accident (City or Location) _____

To Whom was the accident reported? _____

Was an accident report filed? (Y or N) Time of accident? _____

Was a Police Report Made? (Y or N)

To Whom was a citation given?_____

Patient's Attorney Name _____
Address: _____
_____
Telephone Number: _____

Referred By: _____

History:

Driver _____ Passenger _____ Pedestrian _____ Other _____

Were you wearing a seat belt? (Y or N) Make of Vehicle _____
Traveling or stopped facing ____north ____south ____east ____west
Number of vehicles involved in the accident?_____
History of accident:
___ stopped at red light and rear ended
___ hit head on
___ car ran a stop sign or red light and hit _____area of car
___ side swiped
___ lost control of the car
___ other _____
_____
_____

Did you see the accident coming? (Y or N) Brace Yourself? (Y or N)
Did you strike any objects inside the car? (Y or N) What objects?

___ Steering Column	___ Rear view mirror
___ Dash Board	___ Windshield
___ Headrest	___ Driver side window
___ Other _____	___ Can't remember

Did your seat or seat belt break or release upon impact? (Y or N)
Upon impact was your body thrown? How? _____
___ Forward ___Backward ___To the right ___ To the left
What part of your body did you strike? ___Arm/hand ___Back ___Neck
___Head ___Chest ___Face ___Knees ___Ankles ___Shoulder
Were you cut? (Y or N) Did you remain conscious? (Y or N)
Were you able to get out of the car and stand or walk? (Y or N)
Was your car towed away? (Y or N)
Was an ambulance called? (Y or N)

Did you feel any immediate pain? (Y or N) If yes, Where?

___ Headache	Right	Left	Both	sides
___ Neck pain	Right	Left	Both	sides
___ Midback pain	Right	Left	Both	sides
___ Low Back pain	Right	Left	Both	sides
___ Shoulder pain	Right	Left	Both	sides
___ Face pain	Right	Left	Both	sides
___ Elbow pain	Right	Left	Both	
___ Wrist pain	Right	Left	Both	
___ Hand pain	Right	Left	Both	
___ Knee pain	Right	Left	Both	
___ Ankle pain	Right	Left		
___ Foot pain	Right	Left		

After the accident, did you: ___ go home ___ go to hospital
___other_____
If you went to hospital, how did you get there?_____
Name of hospital? _____ Name of physician? _____
Were you seen in the emergency room or admitted? _____
If admitted how long was your stay? _____
What was done at the hospital?

___ Examined	___ Xrays taken	___ Cervical collar
___ Medicated	___ Therapy	___ Stitches
___ Lab work	___ Casts	___ other _____

After your release what did you do? _____
What other doctors did you consult? When? _____
Doctor's name _____
Specialty?_____
What treatment did this other doctor perform?

___ xrays	___ examination	___ diathermy
___ ultrasound	___ traction	___ physiotherapy
___ prescription	___ manipulation	___ other _____

If physiotherapy was rendered, for how long? _____
Did you receive these treatments in his office? _____
How many times per week were you treated? _____
How long were you under his care? _____
Are you still under his care? _____
Did this doctor refer you to another physician? (Y or N)
Whom and where?_____
Have you ever been in any previous accidents of any kind? (Y or N)
If yes, give details. _____
_____
_____
Have you ever been treated for neck or back problems prior to this accident? (Y or N) If yes, please explain. _____
_____
_____
Have you enjoyed good health prior to this accident? (Y or N) If no please explain. _____
_____
Have you lost any time from work since the accident? (Y or N) Are you still off work? (Y or N) Date returned to work? _____

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PERSONAL INJURY PAYMENT POLICY

We appreciate the opportunity to assist with your healthcare. Periodically, an insurance company and/or your attorney (if applicable) may request a reduction in payment for you reclaim due to circumstances of the case, or in the case of pro-rata payments, send less than the total due.

Any reduction for your claim must be presented and approved **PRIOR** to any disbursement to Garner Chiropractic & Wellness Center (GC&WC). In certain circumstances, we understand that you may request assistance with a reduction in the total amount due. For example, if your attorney reduces 10%, then most likely we will reduce 10%. If the attorney requests that the doctor's bill be reduced greater than what they are willing to reduce, please do not expect the doctor to reduce a bill greater than what the attorney is willing to reduce theirs (for example by 30% if your attorney does not reduce any, or reduces by just 10%).

Sometimes we can assist you, and we will always try and help our customers. **But,** we will only consider reduction if GC&WC is notified by you and/or your attorney **before** the claim is paid. **If we are not notified prior to receiving payment, we will not be able to modify any outstanding bill.**

In the case where pro-rata payments are made in pursuant to N.C.G.S Sections 44-49 and 44-50, they will be applied to the total bill. However, you will be liable for the balance due. **Please ask our office and/or your attorney if you need additional clarification on this.**

By signing below, I fully understand that I am responsible for full payment and I fully understand the need for me (name below) and/or my attorney to contact Garner Chiropractic & Wellness Center **PRIOR** to any disbursement that is LESS than 100% of the total amount due.

_____	_____
Printed Name of Patient	**Printed** Clinic Representative
_____	_____
Signature of Patient (Parent/Guardian if under 18 years)	**Signature** of Clinic Representative
_____	_____
Date	Date

ELECTION NOT TO FILE HEALTH INSURANCE CLAIMS
PERSONAL INJURY

The chiropractor(s) at this clinic are participating ("in-network") providers for your health benefit plan. As participating providers, we are obligated to file claims for reimbursement with your plan for all covered services provided to you UNLESS you instruct us in writing not to file.

You have indicated that rather than using your own health insurance, you wish to consider seeking payment from other third-party payers such as the at-fault driver's liability insurance. To help you make an informed decision, please carefully review the following information.

If you elect NOT to file claims on your health insurance:

1.) The clinic will rely on your decision and extend credit to you for the cost of care based on the assumption that your bill will be paid by sources other than your health insurance. You will be required to assign to the clinic the right to receive monies paid by liability insurers, medical payments insurers or other third-party payers to the extent necessary to satisfy your bill.

2.) You will not be required to pay co-payments/co-insurance and/or deductibles that would normally be required by your health benefit plan.

3.) The cost of your treatment will be billed at the clinic's usual rates rather than the discounted rates that routinely apply to services covered by your health benefit plan.

4.) If the combined payments received from other sources do not fully satisfy your bill, you may be personally liable for any unpaid balance.

5.) None of the charges for your treatment will be applied towards satisfying the annual deductibles associated with your health benefit plan.

If you elect TO file claims on your health insurance:

1.) Your health insurance should pay the cost of covered services associated with this accident/injury EXEPT FOR copayments, co-insurance and/or deductibles, which you will be expected to pay directly to the clinic at the time services are rendered.

2.) You will be responsible for paying to the clinic the cost of any non-covered services you elect to receive, and your payment will be due at the time services are rendered.

3.) If your health benefit plan initially pays the clinic for your treatment and later determines that it is not legally responsible for payment, the plan administrator may require the clinic to refund to the plan all or part of the payments received. If that happens, you will become responsible for reimbursing the clinic the amount it was required to refund.

4.) Your health benefit plan requires the clinic to submit claims in a timely fashion and while timely filing requirements vary, most plans require claims to be filed within 3-6 months from date of service. If your action or inaction causes a claim to be submitted late, the claim could be denied, and you would be responsible for paying this clinic for those services which were denied.

Election not to file health insurance claims:

1.) By my signature below, I attest that I have read and understand the above information regarding the options available to me and have been given an opportunity to ask questions and to have those questions answered.

2.) I hereby instruct the clinic not to file claims on my health insurance for services associated with this accident/injury, and I authorize the clinic to seek payment from, and send my treatment records to, other third-party payers who are potential sources of payment.

3.) I understand that the clinic is relying on my decision not to file health insurance claims, and that with regards to claims related to this accident/injury, this decision is irrevocable.

4.) I understand that no subsequent action on my part shall impair the clinic's right to bill and receive payments from third-party payers; subject only to any contractual obligation the clinic may have to my health benefit plan.

_____	_____
Printed Name of Patient	**Printed** Clinic Representative
_____	_____
Signature of Patient (Parent/Guardian if under 18 years)	**Signature** of Clinic Representative
_____	_____
Date	Date

A complete copy of this executed agreement must be maintained in the patient's health record, and a copy must be provided to the patient.

Dr. Perry J. Kirch, DC
1428-D Aversboro Rd
Garner, NC 27529
Phone: (919) 779-2225 (BACK)
Fax: (919) 779-9569

To: Attorney/Insurance Carrier

_____

_____

_____

Doctor

Garner Chiropractic & Wellness Center_____

_____

_____

Patient Name/SS #: _____

Re: Patient Records and Doctor's Lien

I do herby authorize the above doctor at Garner Chiropractic & Wellness Center to furnish you, my attorney/insurance carrier, with a full report of his case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness which occurred/began on _____.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing him for service rendered to me, and to withhold sums from such settlement, claim, judgment or verdict as may be necessary to protect said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all bills submitted by him for service rendered to me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fees.

_____ _____

Patient Signature (Parent/Guardian if under 18 years) **Date**

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above named doctor.

_____ _____

Authorized Signature **Date**

Notice: Please sign, date and return a copy to doctor's office by fax to 919-779-9569. Keep one copy for your records.

ASSIGNMENT OF BENEFITS

In consideration of the willingness of Garner Chiropractic & Wellness Center (GC&WC) to treat me on credit without demand for payment at the time of services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to GC&WC any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on _____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to GC&WC, from any disability benefits, medical payment benefits, liability benefits, health and accident benefits, works compensation benefits, judgements, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due to GC&WC for its services rendered.

I appoint GC&WC as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with GC&WC.

I authorize GC&WC to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to GC&WC for services rendered, including any balance remaining after the application of insurance payments and settlement or judgement proceeds. If GC&WC is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse GC&WC for its costs of recovery, including reasonable attorney's fees.

I further agree this assignment of benefits (AOB) cannot be revoked and the right to receive payment cannot be transferred to any other party or re-asserted by me in any way.

_____

Printed Name of Patient

_____

Signature of Patient (Parent/Guardian if under 18 years)

_____

Date

_____

Witness

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, GC&WC herby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

GC&WC herby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. GC&WC agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

_____ _____

Clinic Name Date

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MOTOR VEHICLE ACCIDENT INFORMATION

Patient Name: _____ Date of Accident: _____

Patient's Information: (MEDPAY) – Call (800) Number on back of Insurance card to get Medpay Info.

Car Insurance Name: _____ Medpay Amount: _____

Claim Number: _____

Adjuster Name: _____

Adjuster Telephone: _____

At Fault (Person who hit you) Information:

Car Insurance Name: _____

Claim Number: _____

Adjuster Name: _____

Adjuster Telephone: _____

If Applicable:

Attorney Name: _____

Attorney Phone: _____

Case Manager: _____

We look forward to assisting you with your injury needs!

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MED PAY INFORMATION

A lot of people have medical benefits ("med pay") included in their automobile policies and don't even realize it. Our office highly recommends that you use your med pay coverage, if you have it, in the event that you are injured in an automobile accident, regardless of who was at fault.

Here are 3 major reasons why we recommend that we file your med pay:

1.) **Med pay is exactly like health insurance. Using it doesn't cause your rates to increase.** If your rates increase, it is not because you filed your med pay, it's most likely because:
   a. It was determined that you were at fault
   b. You received a police citation or ticket
   c. You've been involved in numerous auto accidents within a brief period of time and are considered to be 'high risk'

2.) **Filing your med pay doesn't relieve the other party from having to pay in full for your loss.** On the contrary, by filing your med pay, when you collect from the other driver's liability insurance, a greater amount of settlement will go directly to you because your bill at our office will be less or even paid in full. If the other driver's liability insurance refuses to make payment to you for whatever reason, filing your med pay will help to ensure that you are not stuck with all the medical bills.

3.) **If you have med pay coverage and choose not to file it, then you are paying for an option but not receiving any benefit.**

For the very same reasons, our office also recommends that you file your commercial health insurance. The important thing is to remember that you are not guaranteed of receiving full payment from the other driver's liability insurance company. Filing both your med pay and your health insurance will help to ensure that you are not left to pay for the medical bills.

OUR OFFICE FINANCIAL POLICY

As long as our office is filing your med pay and your health insurance and these companies are continuing to cover your charges, we will waive collection of payment at the time of service. If we receive overpayment on your account, we will be happy to refund the difference to you. Any balance owing will become immediately due and payable should your case not settle within a reasonable time from your release from care.