

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 Numbers: _____

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

Did your seat or seat belt break or release upon impact? (Y or N)

Upon impact was your body thrown? How? _____

What part of your body did you strike? _____
 Forward Backward To the right To the left
 Head Chest Face Knees Ankles Neck 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?

<input type="checkbox"/> Headache	Right	Left	Both	sides
<input type="checkbox"/> Neck pain	Right	Left	Both	sides
<input type="checkbox"/> Midback pain	Right	Left	Both	sides
<input type="checkbox"/> Low Back pain	Right	Left	Both	sides
<input type="checkbox"/> Shoulder pain	Right	Left	Both	sides
<input type="checkbox"/> Face pain	Right	Left	Both	sides
<input type="checkbox"/> Elbow pain	Right	Left	Both	
<input type="checkbox"/> Wrist pain	Right	Left	Both	
<input type="checkbox"/> Hand pain	Right	Left	Both	
<input type="checkbox"/> Knee pain	Right	Left	Both	
<input type="checkbox"/> Ankle pain	Right	Left		
<input type="checkbox"/> 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? _____

<input type="checkbox"/> Examined	<input type="checkbox"/> Xrays taken	<input type="checkbox"/> Cervical collar
<input type="checkbox"/> Medicated	<input type="checkbox"/> Therapy	<input type="checkbox"/> Stitches
<input type="checkbox"/> Lab work	<input type="checkbox"/> Casts	<input type="checkbox"/> 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? _____

<input type="checkbox"/> xrays	<input type="checkbox"/> examination	<input type="checkbox"/> diathermy
<input type="checkbox"/> ultrasound	<input type="checkbox"/> traction	<input type="checkbox"/> physiotherapy
<input type="checkbox"/> prescription	<input type="checkbox"/> manipulation	<input type="checkbox"/> 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? _____



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 your claim 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 EXCEPT 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 hereby 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



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!



MED PAY INFORMATION

A lot of people have medical payment benefits (“med pay”) included in their automobile insurance policies and do not even realize it. Our office highly recommends that you use your med pay coverage, if you have it, if you are injured in an automobile accident, **regardless of who was at fault.**

Here are 3 major reasons why we recommend that you open a med pay claim:

1.) Med pay is exactly like health insurance. Using it does not cause your insurance rates to increase.

If your rates do increase, it is not because you filed your med pay. It is most likely because:

- a. It was determined that you were at fault.
- b. You received a police citation or ticket.
- c. You have been involved in numerous auto accidents within a brief period and are considered ‘high risk’.

2.) Using your med pay does not 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 automobile insurance, a greater amount of settlement will go directly to you because your bill at our office will be less or paid in full. If the other driver’s automobile 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, you are paying for an optional service and not receiving any benefit from that service.

OUR OFFICE FINANCIAL POLICY

If our office is filing your med pay and the insurance company is 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 refund the difference to you. Any balance owed will become immediately due and payable should your case not settle within a reasonable time from your release from care.