PERSONAL INJURY PATIENT

PERSONAL INFORMATION

NAME_____ DATE_____ FILE #_____
BIRTHDATE_____
ADDRESS_____
CITY _____ STATE _____ZIP _____
HOME PHONE _____ WORK PHONE _____
SOCIAL SECURITY _____ SPOUSE'S FIRST NAME _____
EMERGENCY CONTACT _____
ADDRESS _____
PHONE_____RELATIONSHIP

INSURANCE INFORMATION

1) PATIENT'S AUTO INSURANCE

COMPANY NAME _____POLICY # _____
ADDRESS _____
CITY _____ STATE _____ZIP _____
ADJUSTER'S NAME _____PHONE _____

2) *INSURED'S AUTO INSURANCE (DRIVER/OWNER OF CAR YOU WERE IN, IF NOT YOURSELF)*

NAME OF INSURED _____PHONE _____
COMPANY NAME _____POLICY# _____
ADJUSTER'S NAME _____PHONE _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____

3) INSURED'S HEALTH INSURANCE

COMPANY NAME_____ID#_____
PHONE# _____GROUP #_____
ADDRESS_____
CITY _____STATE _____ ZIP _____

ACCIDENT INFORMATION

DID YOU BRING A COPY OF THE POLICE REPORT? YES NO N/A

DID YOU BRING ALL EMERGENCY ROOM AND OTHER DOCTOR'S MEDICAL RECORDS REGARDING THE ACCIDENT? YES NO N/A

DATE OF ACCIDENT _____ TIME _____AM/PM

WHERE WERE YOU SEATED? [ ] DRIVER'S SEAT [ ] PASSENGER SEAT
[ ] MIDDLE SEAT [ ] RIGHT BACK SEAT [ ] MIDDLE BACK SEAT
[ ] LEFT BACK SEAT

WHO OWNS THE CAR? _____MAKE/MODEL _____

WHAT APPROXIMATE DAMAGE WAS DONE TO THE CAR? $_____

ROAD CONDITIONS AT THE TIME OF THE ACCIDENT:
[ ] ICY [ ] WET [ ] CLEAR [ ] DARK

TYPE OF ACCIDENT:
[ ] HEAD ON COLLISION [ ] BROADSIDE (T-BONE) [ ] REAR ENDED
[ ] FRONT IMPACT- REAR ENDED CAR IN FRONT OF YOU [ ] NON-COLLISION
[ ] OTHER _____

EXPLAIN IN DETAIL HOW YOUR ACCIDENT OCURRED:

_____
_____
_____
_____
_____
_____

WERE YOU PRE-WARNED THE ACCIDENT WAS ABOUT TO OCCUR? YES NO

DID YOU BRACE FOR IMPACT? YES NO

WERE YOU WEARING THE SEATBELT AND SHOULDER HARNESS? YES NO

DID YOUR CAR HAVE HEADRESTS? YES NO

IF YES, WHAT POSITION WERE THEY IN?
[ ] TOP OF THE HEADREST EVEN WITH THE BOTTOM OF YOUR HEAD
[ ] TOP OF THE HEADREST EVEN WITH THE TOP OF YOUR HEAD
[ ] TOP OF THE HEADREST EVEN WITH THE MIDDLE OF YOUR BACK

WAS YOUR CAR BREAKING? YES NO

HEAD/BODY POSITION AT THE TIME OF THE ACCIDENT:
[ ] HEAD LOOKING BACK [ ] HEAD STRAIGHT FORWARD
[ ] BODY STRAIGHT IN SITTING POSITION [ ] BODY ROTATED: L OR R

WERE YOUR HANDS ON THE STEERING WHEEL AT THE TIME OF THE ACCIDENT? YES NO

WAS YOUR CAR PUSHED FORWARD AS A RESULT OF THE ACCIDENT?
YES NO IF YES, ESTIMATE THE DISTANCE: _____

DID YOUR CAR HIT ANYTHING ELSE AFTER INITIAL IMPACT? _____

INDICATE IF YOUR BODY PART (LEFT COLUMN) HIT ANYTHING IN THE CAR (RIGHT COLUMN.) DRAW LINES MATCHING THE LEFT AND RIGHT COLUMNS.

HEAD	WINDSHIELD
FACE	STEERING WHEEL
SHOULDER	SIDE DOOR
NECK	DASHBOARD
CHEST	CAR FRAME
HIP	ANOTHER OCCUPANT
KNEE	SEAT
FOOT	SEAT BELT
HANDS	SUN VISOR

WAS THERE GLASS BROKEN OR SHATTERED? YES NO

WERE ANY OF THE FOLLOWING DAMAGED OR BROKEN IN THE ACCIDENT?
[ ] WINDSHIELD [ ] SEAT FRAME [ ] MIRROR [ ] STEERING WHEEL
[ ] DASHBOARD [ ] SIDE/REAR WINDOW [ ] OTHER _____

WAS THE CAR TOWED FROM THE ACCIDENT? YES NO

WAS THE CAR DRIVEABLE? YES NO

AS A RESULT OF THE ACCIDENT WERE YOU:
[ ] RENDERED UNCONSCIOUS [ ] DAZED [ ] CIRCUMSTANCES VAGUE
[ ] SHAKEN BUT COULD FUNCTION [ ] OTHER _____

COULD YOU MOVE ALL PARTS OF YOUR BODY? YES NO
IF YES, WHAT PARTS COULD YOU MOVE? _____

WERE YOU ABLE TO GET OUT OF THE CAR UNAIDED? YES NO
IF NO, WHY NOT? _____

DID YOU RECEIVE CUTS AND BRUISES? YES NO
IF YES, WHERE? _____

IMMEDIATELY AFTER THE ACCIDENT HOW DID YOU FEEL?
_____

DID YOU GO TO THE HOSPITAL AFTER THE ACCIDENT? _____
BY AMBULANCE? YES NO WHICH HOSPITAL? _____

WERE YOU ADMITTED? YES NO

WERE XRAYS OR OTHER TESTS PERFORMED? _____

WHAT TREATMENT DID YOU RECEIVE? _____

DID ANYTHING MAKE YOU FEEL BETTER? _____

OVER THE NEXT 24 HRS, HOW DID YOU FEEL? _____

DID YOU RECEIVE ANY OTHER MEDICAL TREATMENT AFTER THE ACCIDENT? YES NO IF YES, BY WHOM? _____

DID THIS TREATMENT HELP? _____

<u>SYMPTOMS AFTER THE ACCIDENT</u>: (CHECK AS MANY AS APPLY)

[ ] HEADACHE
[ ] NECK PAIN/STIFFNESS
[ ] ARM PAIN, NUMBNESS/TINGLING
[ ] MID BACK PAIN
[ ] LOW BACK PAIN
[ ] LEG PAIN/ NUMBNESS TINGLING
[ ] EYES SENSITIVE TO LIGHT
[ ] PAIN BEHIND THE EYES
[ ] WEAKNESS IN ARMS/LEGS
[ ] DIZZINESS
[ ] IRRITABILITY
[ ] IMPAIRED CONCENTRATION
[ ] CONFUSION
[ ] THROAT PAIN
[ ] PAINFUL SWALLOWING
[ ] POOR SLEEP
[ ] DEPRESSION
[ ] CHEST PAIN
[ ] FAINTING
[ ] BLURRY VISION

[ ] RINGING IN EARS
[ ] LOSS OF BALANCE
[ ] LOSS OF MEMORY
[ ] FATIGUE
[ ] NAUSEA
[ ] VOMITING
[ ] JAW PAIN

WORK STATUS

OCCUPATION _____EMPLOYER _____

HOW LONG HAVE YOU BEEN AT YOUR PRESENT JOB? _____

HAVE YOU MISSED ANY WORK AS A RESULT OF THE ACCIDENT? YES NO

IF YES, HOW LONG? _____

PAST HISTORY

HAVE YOU EVER HAD INJURIES AND/OR COMPLAINTS SIMILAR TO YOUR CURRENT PAIN?
YES NO, IF YES, WHERE? _____WHY? _____

HAVE YOU EVER BEEN IN A CAR ACCIDENT BEFORE? YES NO
IF YES, WHEN? _____ ANY INJURIES? _____

ARE YOU CURRENTLY BEING TREATED BY ANOTHER DOCTOR FOR ANY OTHER HEALTH CONDITIONS? YES NO

IF YES, PLEASE PROVIDE THE CONDITION FOR WHICH YOU ARE BEING TREATED AND YOUR DOCTOR'S NAME
_____
_____
_____

CURRENT MEDICATIONS: _____

SOCIAL HISTORY

[ ] SMOKE: PACKS/DAY _____ HOW LONG? _____
[ ] ALCOHOL: DRINKS/WEEK _____

EXERCISE LEVEL:
[ ] LIGHT [ ] MEDIUM [ ] HEAVY

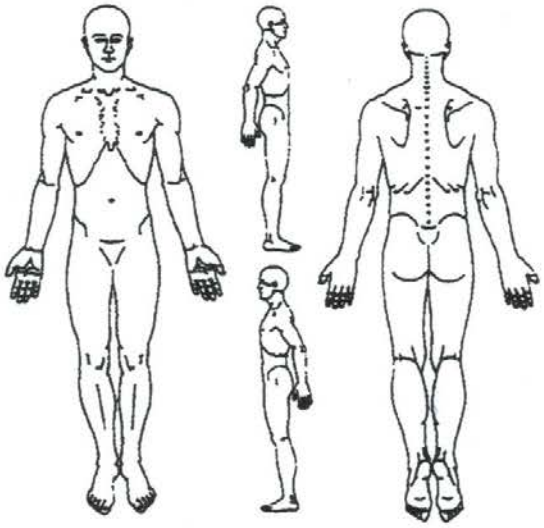
FAMILY HISTORY: _____
_____

SURGICAL HISTORY: _____
_____

PRIMARY CARE PHYSICIAN: _____
PHONE: _____

Place appropriate symbol

Ache = AAAAA
Numbness = NNNNN
Pins and Needles = OOOOO
Burning = XXXXX
Stabbing = / / / / /



ASSIGNMENT OF PROCEEDS, CONTRACTUAL LEIN, AND AUTHORIZATION

(AGREEMENT)

I hereby direct any and all insurance carriers, attorneys, agencies, government departments, companies, individuals, and/or other legal entities ("payers") which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses past or future ("condition") to pay directly to and exclusively in the name of **American Health and Wellness Center, P.C.** such sums as may be owing to **American Health and Wellness Center, P.C.** for charges incurred by me including but not limited to charges for treatment, narrative reports, depositions, testimony and any other charges incurred by me at the office ("charges".) I further grant a contractual lien to **American Health and Wellness Center, P.C.** with respect to my charges applicable to all payers; however, I understand that nothing in this Agreement shall be construed as an election by **American Health and Wellness Center, P.C.** to claim protection under any statutory lien law. For the purpose of this Agreement, "benefits" shall include, but shall not be limited to proceeds from any settlement, judgment or verdict as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorist coverage, third party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purpose stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that in the event a payer refuses to pay **American Health and Wellness Center, P.C.,** I hereby assign to the Office, insofar as permitted by law the following: all of my rights, remedies, and benefits to **American Health and Wellness Center, P.C.,** as well as any and all causes of action that I may have against such payer to the extent of my charges, the right to prosecute such causes of action in my name or in the Office's name and the right to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I hereby direct each attorney to issue a letter of protection to this Office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this Office. I further direct (and this Office herby requests) each attorney to provide immediate notice to the Office regarding any funds received by the attorney relating to my accident, to promptly pay the Office out of such funds, and to provide a full accounting of such funds to the Office upon its request.

I hereby direct all payers to release to **American Health and Wellness Center, P.C**. any information regarding any coverage or benefits which I may have, including but not limited to the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this Office to release any information regarding my treatment, or pertinent to my case(s) to all payers as defined above to facilitate collection under the Agreement. I hereby direct this Office to file a copy of this Agreement together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize **American Health and Wellness Center**, **P.C.**to endorse/sign my name on any and all checks listing me as payee which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize **American Health and Wellness Center, P.C.** to apply any credit balances or charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these charges are related to my condition.

I understand that I remain personally responsible for the total amount due **To American Health and Wellness Center, P.C.** for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services as its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse **American Health and Wellness Center, P.C.** for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of **American Health and Wellness Center, P.C.** and myself. I hereby revoke any previously signed authorizations, whether executed at this Office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of **American Health and Wellness Center, P.C.** and myself. However, should any provision of this Agreement be found to be invalid, illegal, or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall nevertheless, remain in full force and effect.

Patient Name (please print): _____

Patient Signature:_____Date:_____

Name of Custodial Parent or Legal Guardian (please Print):_____

Parent/Guardian Signature:_____Date:_____

In the event that he patient is not represented by legal counsel, we will begin submitting charges to your attention on a periodic incremental basis on HCFA 1500 claim forms. Please apply these charges to any liability, medical payments benefits, personal injury protection, and any other coverage which may apply to our patient. Should the patient choose to retain an attorney, or we learn of such a representation, we will discontinue sending claims to your attention and will submit them to the attorney instead.

As specified in this assignment, and assuming the patient is not represented by legal counsel, please make all payments payable exclusively to **American Health and Wellness Center, P.C.** and send them directly to our office.

Thank you for your attention to this matter. If we can provide any further information or be of any further assistance, please do not hesitate to call.

Sincerely,

Karl Petrie D.C.

American Health and Wellness Center, P.C.
KP/cbm

Enclosure: Assignment of Proceeds, Contractual Lien and Authorization

<u>In the event that the patient is represented by an attorney, we still request that your company honor the enclosed assignment</u>. *Medpay and PIP* do not require the involvement of an attorney: furthermore, state law prohibits attorneys from taking contingency fees out of Medpay and PIP as being "unreasonable fees." Given that an attorney may not collect a contingency fee out of any Medpay or PIP proceeds, we respectfully request that you honor the enclosed agreement.

We appreciate your assistance is resolving these claims upon their receipt. If you have any questions, or need any further information, please do not hesitate to call.

Sincerely,

Karl G. Petrie D.C.

American Health and Wellness Center, P.C.
NRT

Enclosure: Assignment of proceeds, Contractual Lien, and Authorization