MILTON
CHIROPRACTIC & MASSAGE

Personal Injury & Auto Related Accidents

General Information:

Name: _____

Social Security Number: _____

Date of Accident: _____

Were you the: ☐Driver ☐Passenger ☐N/A

Number of people in the accident: _____

If a traffic citation was issued, to whom was it issued?

_____

Were the police called? ☐Yes ☐No ☐N/A

Was a police report filed? ☐Yes ☐No ☐N/A

Were they any witnesses? ☐Yes ☐No ☐N/A

Were you wearing your seatbelt? ☐Yes ☐No ☐N/A

Did airbags inflate? ☐Yes ☐No ☐N/A

Are your work duties limited? ☐Yes ☐No ☐N/A

Billing Related Information:

Have you retained an attorney? ☐Yes ☐No

If yes, Attorney Name: _____

Attorney Phone #: _____

Attorney Email: _____

If insurance claim:

Insurance Company: _____

Adjuster Name: _____

Adjuster Phone: _____

Adjuster Fax: _____

Claim #: _____

After Injury:

Did the accident render you unconscious? ☐Yes ☐No

If yes, how long? _____

Please describe how you felt immediately after the accident

_____

_____

_____

Did you go to the hospital? ☐Yes ☐No ☐N/A

Were you taken by ambulance? ☐Yes ☐No ☐N/A

Have you been seen by any other Doctors since the accident? ☐Yes ☐No ☒N/A

Were x rays taken? ☐Yes ☐No ☐N/A

Was medication prescribed? ☐Yes ☐No ☐N/A

Have you been able to work? ☐Yes ☐No ☐N/A

Indicate any symptoms that are a result of the accident:

☐Dizziness ☐Difficulty Sleeping ☐Fatigue

☐Memory Loss ☐Arm/Shoulder Pain ☐Irritability

☐Headaches ☐Numb hand/fingers ☐Chest Pain

☐Stomachache ☐Mid/Low Back Pain ☐Neck Pain

☐Back stiffness ☐Numb Feet/Toes ☐Nausea

☐Blurred Vision ☐Jaw Problems ☐Leg Pain

☐Shortness of Breath ☐Other: _____

_____

Has your condition changed since the accident?

☐Getting Better ☐Getting Worse ☐No Change

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Personal Injury Payment Agreement

The following is our office policy detailing how your claim can be filed and how payment will be made. The services provided are within the Scope of Chiropractic Practice within the State of Georgia with all charges being normal and customary. Please note that if the correct billing or contact information is not given on page 1, there will be a delay in billing and/or you will be responsible for the entirety of your bill. Please make every effort to provide this information to us in timely fashion.

1) **Your Own Auto Insurance:** Your own auto insurance may have a supplemental policy called "Medical Payments or Med-Pay." This ALWAYS becomes your primary health insurance in the case of an auto accident. It does not matter if you caused the accident, another individual caused the accident, or you were the only individual involved in the accident. Med Pay will cover all of your eligible expenses up to the amount specified on your policy. You have no out of pocket expenses once the Med Pay amounts are confirmed and until they are exhausted.

2) **Liability Insurance:** In this case, another individual has caused the accident and their insurance will be paying your medical bills. The other person's insurance will only pay for your medical bills once care has been completed. They will not be paying your bills while you are undergoing active care. Once your injuries have subsided and you have been released from care, they will review all medical bills and PAY YOU DIRECTLY for all expenses. At this point you MUST satisfy your medical bills with Milton Chiropractic & Massage. To help offset the cost of treatment, patients under this form of care will be required to pay a $45 payment at each visit. This will go against your final bill with Milton Chiropractic & Massage. When settling with the insurance company, be sure to settle for the full amount of the bill with us. This will ensure that you get your $45 payment(s) back.

3) **Attorney:** This option will work much like Liability insurance in that, payments/settlements are made at the end of treatment. You will be responsible for a $45 payment at each visit unless special accommodations are made AND a preferred attorney is chosen. If interested, please request a list of our preferred attorneys. Again, when coming to a settlement be sure to settle of the full amount of the bill with us to ensure your visit payments are paid back to you.

4) **Your own personal health insurance:** This is not a valid option for a true personal injury case. If you have no Med Pay AND you caused the accident or were the only person in the accident, you may be able to use your health insurance. This will involve you paying our cash prices up front and being prepared to pay the full cost of treatment if claims are denied or recouped by the insurance company. We are required by law to disclose any information we have about an injury when submitting a claim to medical insurance companies.

No Show Policy

I understand that I will be charged a $35 "no show fee" for not notifying the staff that I would be unable to make my scheduled appointment.

By signing this page, you are acknowledging that you have read and understand the Personal Injury Payment agreement at Milton Chiropractic & Massage.

Patient Name (print): _____

Patient Signature: _____

Date: _____

Witness Name (print): _____

Witness Signature: _____

Date: _____

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Patient & Provider Contract

This is an agreement between _____, hereinafter called the "patient", and _____, hereinafter called "provider," for full and complete payment of the provider's medical/healthcare services and expenses by the patient from the proceeds of any insurance settlement, judgement at trial, or recovery from any other means or sources the provider's treatment or medical/healthcare bills were used in settlement, judgement, or recovery.

In consideration the provider hereby agrees upon reasonable request and appropriate authorization, reports of care to the patient's attorney without charge to the patient or patient's attorney. In further consideration the provider agrees upon reasonable request and appropriate authorization to meet with the patient's attorney to discuss the treatment of the patient. Such meeting shall be of reasonable duration in consideration and shall be without charge to patient or attorney.

Patient agrees to pay provider regardless of the outcome of any case, claim, or litigation in which the provider's reports, notes, care, and treatment plan are used. Following the outcome of the claim, case, or litigation, if collection becomes necessary, patient will the become liable for interest at the highest current legal rate and provide attorney fees and expenses for successful collection of fees for service. Patient directs and authorizes attorney to provide the provider, upon verbal or written request, to release to provider a copy of settlement statement and settlement check.

The attorney acknowledges receipt of contract and patient requests the attorney follow these directions in making payment from any recovery to the undersigned provider. This agreement shall follow the patient and binds all attorneys or firms handling the patient's case. Patient directs his/her attorney to withhold payment of the provider's total bill for services/expenses for any settlement or recovery from whatever source and to make payment to the provider.

This is an obligation coupled with an interest. It is NOT an agreement for payment based upon the outcome of any claim or litigation. If any clause or provision of this agreement becomes illegal, invalid, or unenforceable for any reason it is the intent of the parties that the remaining part of this agreement not thereby be affected.

This agreement does not waive any right of the provider or preclude the provider from any reasonable actions to collect.

By signing this page, you are acknowledging that you have read and understand the Patient and Provider Contract as part of our personal injury policy at Milton Chiropractic & Massage.

Patient Name (print): _____

Patient Signature: _____

Date: _____

Provider Name (print): _____

Provider Signature: _____

Date: _____

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Medical Authorization

Patient's Full Legal Name: _____ Today's Date: _____

Date of Birth: _____ Date of Accident: _____

I hereby authorize the release of the individually identifiable health information about me that is described below. I understand that disclosure may only be made to the persons or organizations described below. If not specifically limited or restricted, the types of information to be disclosed may include, medical, psychiatric, or psychological records, records of evaluation and treatment for alcohol or drug abuse, records and results of HIV or AIDS testing, or other sensitive information.

Specific description of health information to be disclosed: _____

Approximate dates of treatment: _____

Persons or organizations disclosing the information: _____

Persons or organizations receiving the information: _____

I understand that my decision to sign this form and authorize use and disclosure of my health information is entirely voluntary. I understand that I may revoke this authorization in writing at any time. Unless revoked by me by written request, this authorization is valid.

Patient's Full Legal Name (print): _____

Patient's Signature: _____

Date: _____

If patient is under 18:

Legal Guardian Name (print): _____

Legal Guardian Signature: _____

Date: _____