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

Auto Accident Injury Form

Date of Collision: _____ Hour of Accident: _____ AM/PM

Please describe how the collision happened:

_____

_____

_____

What was your position in the car: **Driver/ Front Passenger/ Left Rear/ Right Rear**

If "Driver," were your hands on the steering wheel? **Both/ Left/ Right**

Did the air bags deploy? **Yes/ No**

Did you strike another vehicle? **Yes/ No** Did another vehicle strike your vehicle? **Yes/ No**

Angle of Impact: **Front/ Back/ Left/ Right/ Other**: _____

1. In relation to the back of your head, was your headrest set: **Low/ Middle/ High**
2. Were you surprised by the impact? **Yes/ No**
    a. If No, how did you brace? **With hands/ With Feet**
3. Where was your head facing at the time of impact? **Straight ahead/ Left/ Right/ Behind**
4. Were you leaning forward at the time of impact? **Yes/ No**
5. What type & year of vehicle were you in? _____
6. What was the approximate speed of your vehicle when the accident occurred? _____mph
7. What type and year of the vehicle struck yours? _____
8. What was the approximate speed of the other vehicles at the time of impact? _____mph
9. Were you wearing a seatbelt? **Yes/ No** What type: **Lap Belt/ Shoulder Belt/ Both**
10. Did you feel pain immediately after the accident? **Yes/ No**
11. Were you rendered unconscious as a result of the accident? **Yes/ No**
12. Did you strike anything in the vehicle at the time of impact? **Yes/ No**
    a. If "YES" specify what part of the body struck what? (head, chest, chin, shoulder, knee, ect.)

☐ Steering Wheel	☐ Windshield
☐ Dashboard	☐ Roof
☐ Left Side Door	☐ Right Side Door
☐ Left Window	☐ Right Window
☐ Other	☐

13. Did your seat break or bend? **Yes/ No**
14. Immediately following the accident, how did you feel? Circle all that apply. **Dizzy/ Dazed/ Weak/ Upset/ Disoriented/ Nervous/ Nauseous/ Other**: _____

Police & Ambulance

15. Was the accident reported to the police? **Yes/ No**
16. Were traffic citations issued? **Yes/ No** If Yes, to whom? _____
17. Did you go to the hospital? **Yes/ No** If Yes, When? _____
18. If Yes, how did you go? **Ambulance/ Police Car/ Private Transportation**
19. Were you admitted**?** **Yes/ No** If Yes, how long? _____
20. Name of Hospital: _____ Attended by Dr. _____
21. What treatment given? Circle all that apply. **None/ X-rays/ Pain medication/ Stitches/ Muscle Relaxers/Bandaged/ Cervical Collar/ Physical Therapy/ Instructed Regarding Concussion/ Instructed Regarding Sprains & Strains/ Instructed to call an Orthopedist/ Instructed to call Private Physician/ Referred to Office/ Other**: _____
22. What other doctor have seen as a result of this injury? _____
23. Do you have difficulty in excessive: **Standing/ Walking/ Riding/ Bending/ Twisting**
24. Do you have difficulty in excessive lifting? **Light/ Moderate/ Heavy/ Repetitive**
25. Symptoms other than above: _____

Please draw a diagram of the accident in this box:

_____ _____

Patient Signature **Date**

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

Forever Young Chiropractic
138 Eastbrooke Court, Suite 130
Mt. Washington, KY 40047
Phone: 502-538-0222
Fax: 502-538-0282

Payment Policy

Prompt care is essential for our patients who have been involved in motor vehicle accidents. When an insurance company is involved, it is our policy to bill the responsible insurance company services rendered. We agree to wait for the insurance company to remit payment directly to us, allowing our patients to focus on restoring health, while making the financial aspect of the situation less burdensome.

There have been times when the insurance company has sent payment to our services directly to the patient, failing to honor our patient's request that we be paid directly. When that occurs, the patient accepts responsibility to promptly forward that payment to us.

On several occasions, patients have decided not to honor that obligation to us, causing us serious problems that jeopardize our clinics very survival. Therefore, our policy is, and you, our patient agree to the following conditions when we agree to bill the responsible insurance company for services rendered to you, and the insurance company pays you instead of us:

1. You will pay us the full amount of the insurance company's payment for our services within 5 days of receipt of payment.
2. If you do not pay us within 5 days of receipt of the payment for our services, you agree to pay us 18% interest, or the maximum allowable consumer interest in this state. Interest will accrue beginning the 5th day after you receive payment.
3. If we must turn your debt over to collection, you agree to pay for all of our services, accrued interest, collection costs & legal fees.

When it is determined that you have Medical Payment insurance, by signing this form you are giving Forever Young Chiropractic authorization to bill your personal insurance company and receive payment directly.

Patients Printed Name: _____
Patient's Signature: _____
Today's Date: _____

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

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138 Eastbrooke Court, Suite 130
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Release of Information

I hereby instruct and authorize my attorney, who is representing me as a result of the motor vehicle accident that occurred on _____, that services provided by Forever Young Chiropractic will be paid in full from proceeds of any settlement or judgment resulting out of the aforementioned accident. Payment for those services should be forwarded within 5 days of disbursement of funds.

I hereby authorize and instruct my adjustor/ attorney named below to release the following information to my healthcare provider, Forever Young Chiropractic; 138 Eastbrooke Court, Suite 130, Mt. Washington, KY 40047

The information to be supplied includes:

1. Case status as requested
2. The amount of total settlement
3. Case settlement dates
4. Settlement disbursement breakdown of expenses
5. Copies of settlement checks

Attorney Name & Contact Information:

_____
_____
_____
_____

Patients Printed Name: _____
Patient's Signature: _____
Today's Date: _____

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

Forever Young Chiropractic
138 Eastbrooke Court, Suite 130
Mt. Washington, KY 40047
Phone: 502-538-0222
Fax: 502-0282

Doctor's Lien

To: Attorney
_____
_____
_____

I do hereby authorize the above Doctor to furnish you, my attorney, with a full a report of his examinations, diagnosis, treatment, prognosis, etc., of myself in regards to the accident in which I was involved.

I hereby authorize and direct you to, my attorney to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor. And, I hereby further give lien on my case to said doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to my attorney or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

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

Patient's Printed Name: _____ Date: _____

Patient's Signature: _____

The undersigned being attorney if records for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor above named.

Attorney's Printed Name: _____ Date: _____

Attorney's Signature: _____

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

Credit Guarantee
Auto Insurance Assignment
Personal Balances

Insurance Assignment
Our Auto Insurance Assignment Program is designed to render you immediate care and keep you out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your insurance carrier on your behalf and wait up to 6 months for payment. Please remember, however, that you are ultimately responsible for payment. As a prerequisite, we ask that you provide a credit card to guarantee payment of your bill and that you provide us with the following:

Your complete automobile insurance information
Your family health insurance plan information

Filing Procedure

We will periodically submit claims on your behalf to both your automobile & health insurance carriers. Any overpayments resulting in credit balances will be refunded promptly at the conclusion of your care.

Balances not paid within 6 months after conclusion of your care will be charged to your designated credit card below. You will be sent a payment voucher. Should settlement be reached prior to 6 months grace period or should your care be terminated for any reason prior to your physician dismissal all balances become due immediately, will be charged to your credit card and are subject to monthly interest charges.

Credit Card:

- ☐ AMEX
- ☐ MC
- ☐ ViSA
- ☐ DISCOVER

Card Holder Name: _____
Card # _____ EXP Date: _____

I agree to the above terms and authorize you to bill the credit card. I understand that should payment not be received within 6 months after termination of my care or should I terminate care before being dismissed by your physician, I will be charged the amount outstanding on my account.

Patients Printed Name: _____
Patient's Signature: _____
Today's Date: _____