AUTO INJURY

PERSONAL INFORMATION
Today's Date_____ Date of Accident_____
Name_____ Date of birth_____ S.S. #_____-_____-_____
Address_____ City_____ State_____ Zip_____
Home phone_____ Work phone_____ Cell phone_____
Email_____ Ok to send you our monthly e-newsletter? Yes No
Spouse's name (if married) _____Children?(names/ages)_____
_____
Emergency contact_____Phone_____

EMPLOYMENT INFORMATION
Employer_____ Address_____
Job title_____ How many hours per week do you normally work?_____
What are the physical requirements of your job?_____
_____
How have your injuries affected your ability to work?_____
_____
Please list any days of work missed as a result of this accident_____
Is light-duty work available, if needed? Yes No

MEDICAL HISTORY
Have you ever been injured in a previous auto accident (sore afterwards)? Yes No
If yes, approximate dates, and describe your injuries_____
_____
Please list <u>any</u> significant injuries or physical traumas you have had during your life_____
_____
Have you had ongoing problems as a result of any of these injuries? Yes No
If yes, please describe_____
_____
Please list <u>any</u> current health problems_____
_____
Please list all medications you currently take_____
_____
Please list vitamins/supplements you take_____
_____

Clark Chiropractic Center • 418 E. Diamond Ave, Gaithersburg, MD 20877
(301) 926-1500 • Fax (301) 926-0462

ABOUT THE ACCIDENT

Date of accident_____ Time of day____AM/PM

Please describe the accident in your own words:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please illustrate what happened in your accident:

Police on the scene? Y N / Report filed? Y N

You were the:(check one)

☐ Driver ☐ Front seat Passenger

☐ Backseat Passenger (circle one) Left Right

Were you wearing your seatbelt? Y N

Did the airbags deploy? Y N

Were you aware of the impending crash? Y N

Year, make, model of your vehicle:_____

Describe other vehicle:_____

Type of damage:_____

Amount of damage to auto: $_____

Road conditions:_____

Did your head or body strike any parts of the vehicle? Please describe: _____

Was the seat back or head restraint position altered by the accident? Y N

Did you lose consciousness at any point? Y N If so, for how long?_____

Did you go to the hospital following the accident? Y N / Which one?_____

If yes: How did you get there?_____

What tests were taken and what were the findings?_____

What medications were prescribed? _____

What medical attention have you received so far?_____

Please list any other passengers with you:_____ _____

VI. SYMPTOMS

Check symptoms you have noticed since the accident:

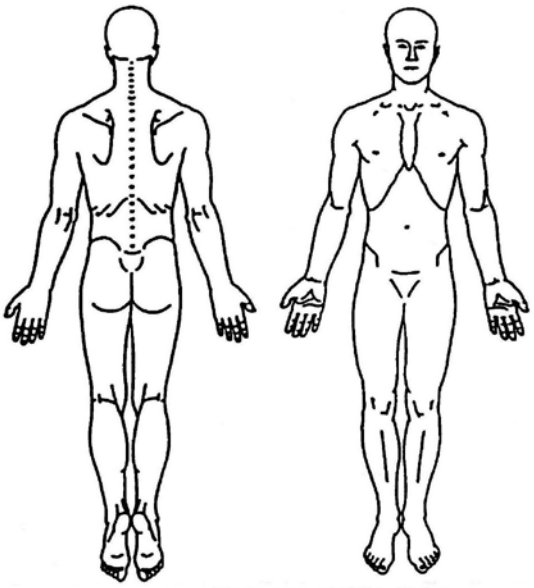
❑ Neck pain or stiffness	❑ Loss of Memory
❑ Upper back pain	❑ Loss of Smell or Taste
❑ Mid back pain	❑ Light bothers Eyes
❑ Lower back pain	❑ Trouble focusing (vision)
❑ Jaw Problems	❑ Dizziness
❑ Shoulder pain	❑ Fatigue
❑ Chest Pain	❑ Nausea
❑ Pain/Numbness in arms/hands	❑ Trouble with balance
❑ Pain/Numbness in legs/feet	❑ Trouble falling asleep
❑ Headaches	❑ Wake up during the night

Other symptoms:_____

Where are you hurting the worst? _____ Is your condition getting worse, better, or staying the same?_

_____

Please mark the location(s) of your pain or numbness, and number from <u>most</u> bothersome to <u>least</u>:



Bruising? Where?_____

Personal Injury Authorization and Assignment

PATIENT'S NAME: _____

PATIENT'S AUTOMOBILE INSURANCE INFORMATION:

Ins. Co. Name: _____ Name of insured: _____
Address: _____ SS# of insured: _____
Phone number: _____ Relationship to insured: _____
Have you reported auto damage? Y N Medical injuries? Y N
Auto claim #: _____ Medical injury claim #: _____

OTHER DRIVER'S AUTO INSURANCE INFORMATION:

Name of driver: _____ Their Policy #: _____
Their Ins. Co.: _____ Phone #: _____

MY ATTORNEY'S INFORMATION:

Name: _____ Phone number: _____
Address: _____

No matter who is at fault for this automobile accident, your medical expenses are almost always paid for by your own personal injury policy (PIP). In the event you waived purchasing personal injury protection or your PIP coverage is exhausted, we can file with your health insurance. If they do not cover our services we can refer you to a qualified attorney.

MY HEALTH INSURANCE INFORMATION:

Company name: _____ Phone number: _____
Policy #: _____ Group #: _____
Address: _____
Name of insured: _____ SS# of insured: _____
Patient's relationship to insured: _____

I understand that in order for this office to accept assignment (file your insurance claims for you and wait for payment) I must first provide them with the above information. Otherwise, payment for today's visit is due at the time of service. Until Clark Chiropratic Center verifies this information, I further understand that any subsequent visits will also be my financial responsibility and will be due at the time of the office visit.

I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports and forms to assist in collecting from my insurance company.

I, the undersigned, hereby authorize permission to my insurance company that all bills submitted by Clark Chiropratic Center be paid directly to them. In the event that my policy prohibits this, I direct that any payment to me as the result of this claim be mailed to Clark Chiropratic Center.

_____ _____
Signature **Date**

Clark Chiropratic Center • Dr. Steven E. Clark, Chiropractor
418 E. Diamond Avenue • Gaithersburg, MD 20877 • (301) 926-1500 • fax (301) 926-0462

CLARK CHIROPRACTIC CENTER

Dr. Steven E. Clark, Chiropractor
418 East Diamond Avenue, Gaithersburg, MD 20877
(301) 926-1500

Authorization and Assignment

I hereby authorize Dr. Steven E. Clark to furnish, upon request, to my attorney whose signature appears below, copies of bills and medical reports of examination, diagnosis, treatment, prognosis, etc. pertaining to, but not limited to injuries sustained by me and/or any of my children and/or dependents resulting from injuries on _____

This authorization to obtain records and information contained in this paragraph expires one year from this date unless extended or renewed in writing by me.

I hereby irrevocably authorize and direct said attorney receiving such medical reports to pay Dr. Clark his charge for services rendered by him, or any balance thereof, which shall include his charge for attendance in court, if required, as an expert witness whether he testifies or not, and for reports made or depositions given in this matter. Unless Dr. Clark is instructed otherwise, he will assume that a narrative report is expected upon my release from his care.

Said payment is to be made from any monies received by said attorney as a result of compromise, or verdict, or by way of collection of a judgment on my claim for injuries sustained on the above date. Payment of this amount as herein directed shall be the same as if paid by me. This authorization to pay Dr. Clark shall constitute and be deemed an assignment of so much of my recovery as shall cover the aforesaid bill.

I also authorize Dr. Clark to file for and collect his fees from either my health insurance and/or Personal Injury Protection insurance if and when available. In the event that my Personal Injury coverage is paid directly to me, I agree to pay Dr. Clark immediately from these proceeds, with his bill taking precedence over any other financial demands, which may have arisen as a result of this accident.

I further understand that payment for services rendered is not contingent upon recovery and this does not relieve me of my personal obligation to pay the charges for services rendered, and I further agree to pay such costs that may be incurred in the collection of these charges including attorneys fees and collection costs.

It is further understood that the statute of limitations in this State is three (3) years from the time said services were last performed, and I further understand that because of long delays in trial dockets, many cases are not tried or settled until a date which is beyond three (3) years after the last service was performed. In view of this, I hereby agree that the statute of limitations with respect to any claim for services mentioned above will not begin until there is a denial in writing by me of any balance claimed to be due and owing to you by me.

I understand that payment to Dr. Clark for professional services rendered is not to be delayed during the pending of my claim. In the event of a dispute as to the charge for services rendered, I hereby authorize and direct my said attorney to withhold the full sum claimed by Dr. Clark until such time as the matter is settled by compromise or judgment.

Name _____ Date_____

Witness _____ Date _____

I accept the above assignment and agree to observe the terms set forth, and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Dr. Clark's interests.

Name (attorney)_____ Date _____

OFFICE POLICY AND CONSENT TO TREATMENT

APPOINTMENTS

On your first visit the doctor will take a thorough history, and perform a thorough examination, possibly including x-rays. On your second visit the doctor will recommend a treatment plan, laying out the number and frequency of appointments necessary to resolve your problem. You will get the best results, and save time and money, by following this schedule as much as possible. **Please schedule your appointments as far in advance as possible; and should you need to miss an appointment, please do your best to make it up within 7 days.**

PATIENTS WITH INSURANCE

As a courtesy, we will call to verify your insurance coverage, and explain it to you. **Please understand that we are sometimes given incorrect information, and insurance companies have no legal obligation to honor what they tell us.** It is always a good idea to call yourself to double check on your coverage, and to ask for the name of the agent that you speak with. After this is done, and any deductible has been met, we will collect your co-pay at the time of service and wait up to 60 days for your insurance to reimburse the rest.

We file claims monthly. **Should your insurance company deny payment or take over 60 days to pay, you will need to pay any outstanding balance at that time, and resolve the problem with your insurance company. We will provide you with any records you may need to accomplish this, but we cannot fight the insurance company for you.** Your insurance policy is a contract between you and your insurance company. Filing insurance claims is a courtesy provided to you without charge, and in no way relieves you of the responsibility for your bill.

We do not file for secondary insurance, but we will be happy to print out your claims so that you may do so.

ZERO BALANCE POLICY

Our office policy is that all accounts must be current before any further services can be rendered.
After 60 days, any amount due will automatically enter the collection process. Any fees incurred in collecting the overdue amount will be automatically added to the bill.

CONSENT TO TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays on me by the doctor or authorized staff member. I have had the opportunity to discuss with the doctor or staff member the nature and purpose of these procedures, and any concerns I may have. I understand that results are not guaranteed.

I further understand that although chiropractic treatment is extremely safe, no medical or physical treatment is without risk. I do not expect the doctor to be able to anticipate and explain all possible risks, and wish to rely on his judgment as to the safety and appropriateness of any treatment provided to me.

I have read and understand the above, and I consent to all examinations and care as deemed appropriate by the doctor for my present condition, and for any future conditions for which I may seek care. I realize that I may ask any questions to the doctor either before or after I sign this contract, and I understand that my consent can be withdrawn at any time.

(Signature)_____ (Date)_____

CLARK CHIROPRACTIC CENTER

CLARK CHIROPRACTIC CENTER
PRACTICE'S REQUIREMENTS

The Practice:

(a) Is required by federal law to maintain the privacy of your PHI (Protected Health Information) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Under the Privacy Rule, may be required by State Law to grant greater access or maintain greater restriction on the use or release of your PHI than that which is provided by under Federal law.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that is maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE APRIL 15, 2003

This notice is in effect as of 04-15-03.

PATIENT ACKNOWLEDGEMENT

By signing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

PATIENT SIGNATURE: _____

PATIENT NAME: _____

DATE: _____