

Family Chiropractic Center of Sanford

1100 Carthage Street
Sanford, North Carolina 27330
(919) 775-2114 (919) 776-4032

To All Personal Injury Patients

We will file all insurance associated with this accident, however we must have the accurate information to do so. If we do not have the accurate information, you will be responsible to pay for services at the time they are rendered. You must provide us with all insurances you wish to file within the 2 days of your initial treatment or there will be a \$5.00 charge for any additional claims.

Please provide us with the following information for each insurance company:

INSURANCE # 1:

Name of insurance co.: _____

Address of insurance co.: _____

Phone # of insurance co.: _____

Claim or Policy #: _____

Adjustor's Name: _____

INSURANCE # 2:

Name of insurance co.: _____

Address of insurance co.: _____

Phone # of insurance co.: _____

Claim or Policy #: _____

Adjustor's Name: _____

I have read and understand the above statement. I understand that I am responsible for any charges incurred at Family Chiropractic Center of Sanford. I further understand that all insurance payments will be sent to Family Chiropractic Center of Sanford, including Med Pay, and in the case of any overpayment, a refund will be issued upon settlement of my case.

Signature _____ Date _____

Witness _____

Authorization and Assignment

To: Dr. Skip Austin, D. C.

In consideration of your undertaking to treat me, I agree to the following:

Authorization to Release Information

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

Assignment of Cause of Action

In the event any insurance company is obligated by contractual agreement to make payment to me or to you for the demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is/are believed to correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due), I personally owe you, and agree to pay in a current manner.

Authorization to Pay Directly to Doctor

To: _____
(Name of attorney and/ or insurance company)

In consideration of the chiropractic services rendered and to be rendered by him I authorize and direct the payment to the doctor named above of any sum I now or hereafter owe him by you, my attorney, out of the proceeds of any settlement of my case, and/ or by any insurance company obligated to reimburse me for the charges for his services or otherwise obligated to reimburse me for the charges for his services or otherwise obligated to make payment to me or him based in whole or in part upon the charges made for his services.

Acknowledgement and Understanding

I hereby acknowledge that I am receiving (or about to receive) health care services at the Family Chiropractic Center of Sanford office, and that I have been advised that the doctor(s) providing the services is/ are willing to wait for payment for these services, provided that these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim.

I understand that if it is determined either:

- (1) That there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor(s) or make other provisions for the protection of the interest of the doctor(s); or
- (2) If a liability claim exists, or my attorney refuses to agree to protect the interest of the doctor(s), or if I have not engaged the services of an attorney;

Then payment for services rendered by the doctor(s) at the Family Chiropractic Center of Sanford office will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever comes first.

Patient's Signature

Date

Witness

NOTICE OF DOCTOR'S LEIN

TO: _____

RE: Patient: _____

Claim Number: _____

Date of Accident: _____

I do hereby authorize Family Chiropractic Centers at 1100 Carthage Street Sanford, NC 27330, to furnish you with my medical records including examination reports, radiographic reports, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I involved.

I hereby authorize and direct you to pay directly to said doctor such sums as may be due the 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 and fully compensate said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you , 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 service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration for his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may be eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident and I instruct my attorney or insurance to do the same and promptly deliver a copy of this lien to any substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if the insurance company does not wish to cooperate in protecting the doctor's interest, the doctor will no await payment but may declare the entire balance due and payable. I further direct the insurance company to pay said doctor one hundred percent of all chiropractic cost associated with my treatment. I understand all costs associated with my care and believe them to be necessary , reasonable and customary.

Patient's Signature _____ Date _____

The undersigned acknowledges receipt of this lein

Date _____ Authorized Signature _____

Please date, sign and return a copy to doctor's office. Please fax copy to our office at (919) 776-4032 for confirmation of receipt. Thank you

ATTENTION PERSONAL INJURY PATIENTS

As a courtesy to our patients who have been involved in an accident and have retained an attorney, we will wait for payment until the attorney has made a settlement.

All financial agreements are between Family Chiropractic Center of Sanford and you the patient and not with Family Chiropractic Center of Sanford and the attorney which means the patient has overall responsibility for all charges incurred with Family Chiropractic Center of Sanford.

If upon settlement by the attorney, the full bill is not paid, the patient is responsible for the remaining charges plus any interest charges. The patient will also be responsible for any fees acquired as a result of any collections actions deemed necessary.

By Family Chiropractic Center of Sanford agreeing to wait for payment, you as the patient must ensure that your attorney makes payment for all charges incurred.

I understand the above statement and agree that I am responsible for all charges incurred with Family Chiropractic Center of Sanford. I understand that Family Chiropractic Center of Sanford has agreed to wait for payment until my case is settled and I in turn agree to protect the interest of Family Chiropractic Center.

Patient Name (printed) _____

Patient Signature _____

Guardian Signature _____

Date _____

D. HOSPITAL VISIT AFTER ACCIDENT / INJURY

3. If a CAT Scan was performed, of what body part(s)?

- Head Upper / Mid Back Chest / Rib Cage
 Neck Lower Back Abdomen
 Other _____

4. If a MRI was performed, of what body part(s)?

- Head Upper / Mid Back Chest / Rib Cage
 Neck Lower Back Abdomen
 Other _____

5. What was the diagnosis given at the hospital?

a. Head

- Concussion Skull Fracture Lacerations
 Contusions Other _____

b. Jaw

- Strain Sprain Dislocation
 Fracture Whiplash Lacerations
 Contusions Other _____

c. Neck

- Strain Sprain Dislocation
 Fracture Whiplash Disc Injury
 Lacerations Contusions
 Other _____

d. Upper / Middle Back

- Strain Sprain Dislocation
 Fracture Disc Injury Lacerations
 Contusions Other _____

e. Lower Back

- Strain Sprain Dislocation
 Fracture Disc Injury Lacerations
 Contusions Other _____

f. Pelvis

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

g. Chest / Rib Cage

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

h. Abdomen

- Strain Lacerations Contusions
 Other _____

i. Shoulders

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

j. Arms

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

k. Elbows

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

l. Forearms

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

m. Wrists

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

n. Hands / Fingers

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

o. Buttocks

- Strain Sprain Lacerations
 Contusions Other _____

p. Hips

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

q. Thighs

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

r. Knees

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

s. Legs

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

t. Ankles

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

u. Feet / Toes

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

v. Other

- Strain Sprain Dislocation
 Fracture Lacerations Contusions

w. Describe any additional diagnosis given:

D. HOSPITAL VISIT AFTER ACCIDENT / INJURY

6. What treatment was administered at the hospital?

- | | | | |
|--|------------------------------------|---------------------------------|----------------------------------|
| <input type="checkbox"/> Oral Medication | <input type="checkbox"/> Sutures | <input type="checkbox"/> Splint | <input type="checkbox"/> Collar |
| <input type="checkbox"/> Injection | <input type="checkbox"/> Ice Packs | <input type="checkbox"/> Cast | <input type="checkbox"/> Support |
| <input type="checkbox"/> Topical Antiseptics | <input type="checkbox"/> Hot Packs | <input type="checkbox"/> Brace | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Bandages | <input type="checkbox"/> Other | | |

7. Instructions Given When Discharged From Hospital

a. Were you told to see?

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> General Practitioner | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Neurologist |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Internist |
| <input type="checkbox"/> General Surgeon | <input type="checkbox"/> Plastic Surgeon | |
| <input type="checkbox"/> Other | | |

b. What recommendations were made?

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> No Further Care | <input type="checkbox"/> No Follow-up Instructions | <input type="checkbox"/> Observation |
| <input type="checkbox"/> Rest | <input type="checkbox"/> Ice | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Time Off Work | <input type="checkbox"/> Collar | <input type="checkbox"/> Support |
| <input type="checkbox"/> Other | | |

c. Were medications prescribed?

- | | | | |
|--------------------------------|--|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Anti-inflammatory | <input type="checkbox"/> Antibiotic | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Other | | | |

E. FOLLOWING THE ACCIDENT / INJURY

1. How much later did additional symptoms develop?

- | | | | |
|--------------------------------------|--------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Immediately | <input type="checkbox"/> Hours | <input type="checkbox"/> That Evening | <input type="checkbox"/> Next Morning |
| <input type="checkbox"/> Days | <input type="checkbox"/> Week | <input type="checkbox"/> Month | <input type="checkbox"/> |

2. What additional symptoms developed?

a. Head

- | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Other | | | |

b. Jaw

- | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Other | | | |

c. Neck

- | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Other | | | |

d. Upper / Middle Back

- | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Other | | | |

e. Lower Back

- | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Other | | | |

f. Pelvis

- | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Other | | | |

g. Chest / Rib Cage

- | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Other | | | |

h. Abdomen

- | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Other | | | |

i. Shoulders

- | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Other | | | |

j. Arms

- | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Other | | | |

k. Elbows

- | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Other | | | |

l. Forearms

- | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Other | | | |

m. Wrists

- | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Other | | | |

n. Hands / Fingers

- | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Other | | | |

o. Buttocks

- | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Other | | | |

p. Hips

- | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Other | | | |

q. Thighs

- | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Other | | | |

r. Knees

- | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Other | | | |

s. Legs

- | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Other | | | |

t. Ankles

- | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Other | | | |

u. Feet / Toes

- | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Other | | | |

v. Other

3. Since your accident / injury have you suffered from?

- | | | |
|---|---|--|
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Reduced Vision | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Impaired Hearing | <input type="checkbox"/> Constipation | <input type="checkbox"/> Inability To Hold Urine |
| <input type="checkbox"/> Ringing In Ears | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Painful Urination |

E. FOLLOWING THE ACCIDENT/INJURY (Continued)

4. Additionally have you experienced any of the following?

- Anxiety
- Depression
- Mood Swings
- Nervousness
- Poor Memory
- Tension
- Other
- Convulsions
- Dizziness
- Headaches
- Fainting
- Loss Of Balance
- Fatigue
- Restlessness
- Insomnia
- Light Sensitivity
- Reduced Appetite
- Weakness
- Weight Gain
- Weight Loss

5. Are you restricted in any of the following areas as a result of this accident/injury?

- Daily Living
- Occupational/Work
- Recreational Activities
- Other

6. Have you missed work due to this accident / injury?

- Missed No Work
- Missed Work From: / / To: / /
- Other
- Limited Work Activity

7. Did you self treat your symptoms?

- Ice
- Heat
- Bed Rest
- Over-The-Counter Medication
- Other

8. Did you seek medical care elsewhere?

a. General Practitioner Name:

Diagnosis And Treatment Recommendation:

b. Internist Name:

Diagnosis And Treatment Recommendation:

c. Chiropractor Name:

Diagnosis And Treatment Recommendation:

d. Neurologist Name:

Diagnosis And Treatment Recommendation:

e. Orthopedist Name:

Diagnosis And Treatment Recommendation:

f. General Surgeon Name:

Diagnosis And Treatment Recommendation:

g. Plastic Surgeon Name:

Diagnosis And Treatment Recommendation:

h. Psychologist Name:

Diagnosis And Treatment Recommendation:

i. Other Name:

Type:

Diagnosis And Treatment Recommendation:

9. Have you had any of the following tests?

- CT Scan
- MRI
- Electrodiagnostic Studies
- Other

10. What is the reason for seeking today's consultation?

- Persisting Complaints
- Worsening Of Symptoms
- Other

F. INSURANCE / ATTORNEY INFORMATION

1. Have you contacted an insurance adjuster or representative regarding this claim? Yes No

Company:

Adjuster:

Claim #:

2. Have you engaged services of an attorney? Yes No

Attorney:

Address:

City:

State:

Zip:

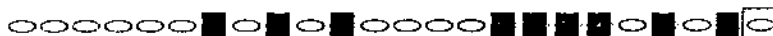
Phone:

3. Have you filed an accident / injury report? Yes No

4. Have you filed for insurance benefits? Yes No

Patient's Or Guardian Signature:

Date:



D. AT MOMENT OF IMPACT

1. Were you prepared for the accident?
 Accident A-Complete Surprise
 Aware Of Impending Collision And Braced For Impact

2. Foot On Brake Pedal
 a. Was your foot on brake pedal at impact? Yes No

- b. Was it knocked off pedal by impact? Yes No
3. Use Of Restraints
 a. Restraint Belts
 1. Were you wearing a restraint belt? Yes No
 2. What type of restraint belt were you wearing?
 Shoulder-Lap Belt Shoulder Belt Lap Belt

- b. Headrests
 1. Was vehicle equipped with headrests? Yes No
 2. What position was the headrest in?
 Low Middle High Don't Know

- c. Air Bags
 1. Was vehicle equipped with air bags?
 Yes No Unsure
 2. Did the air bags deploy? Yes No

4. Your Body
 a. What was your body position at impact?
 Straight Stouched Forward Rotated: Right Left
 Don't Recall Other
 b. What direction was your body thrown?
 Forward\Backward Backward\Forward Sideways
 Across Vehicle Outside Vehicle Under Vehicle
 Don't Recall Other

5. Your Head And Neck
 a. What position were your head/neck in at impact?
 Straight Tilted Forward Rotated: Right Left
 Don't Recall Other
 b. Through what motion were your head/neck pitched?
 Forward\Backward Backward\Forward Sideways
 Don't Recall Other

- b. Right Upper Extremity (Arm)
 Steering Wheel Dashboard Windshield
 Right Side Door Left Side Door Armrest
 Right Window Left Window Headrest
 Ceiling Console Shift Lever
 Front Seat Rear View Mirror
 Other

- c. Left Upper Extremity (Arm)
 Steering Wheel Dashboard Windshield
 Right Side Door Left Side Door Armrest
 Right Window Left Window Headrest
 Ceiling Console Shift Lever
 Front Seat Rear View Mirror
 Other

- d. Torso
 Steering Wheel Dashboard Windshield
 Right Side Door Left Side Door Armrest
 Right Window Left Window Headrest
 Ceiling Console Shift Lever
 Front Seat Rear View Mirror
 Other

- e. Right Lower Extremity (Leg)
 Steering Wheel Dashboard Windshield
 Right Side Door Left Side Door Armrest
 Right Window Left Window Headrest
 Ceiling Console Shift Lever
 Front Seat Rear View Mirror
 Other

- f. Left Lower Extremity (Leg)
 Steering Wheel Dashboard Windshield
 Right Side Door Left Side Door Armrest
 Right Window Left Window Headrest
 Ceiling Console Shift Lever
 Front Seat Rear View Mirror
 Other

2. Did your body strike any other objects?
 Description Of Other Objects Your Body Hit:

E. RESULT OF IMPACT

1. Which objects in the vehicle did the force of the collision cause your body to strike?
 a. Head
 Steering Wheel Dashboard Windshield
 Right Side Door Left Side Door Armrest
 Right Window Left Window Headrest
 Ceiling Console Shift Lever
 Front Seat Rear View Mirror
 Other

F. ADDITIONAL INFORMATION

Additional Information About Your Automobile Accident:

Patient's Or Guardian Signature: _____ Date: _____