Patient Information (Please print)

Name _____ Date_____ SNN_____

Address_____ City_____ State_____ Zip_____

Birth Date_____ Age_____ Home Phone_____

Work Phone_____ Cell Phone_____ Email_____

Sex (Please Circle): Male Female

Employer_____ Occupation_____

Business City_____

Emergency Contact Name_____ Emergency Contact Number_____

Auto Insurance Company Responsible for Payment : MedPay_____ Claim #_____

Claim Adjuster:_____ Phone Number:_____

Auto Insurance Company Responsible for Payment : 3rd Party _____ Claim #_____

Claim Adjuster:_____ Phone Number:_____

Assignment and Release

I certify that I have read and understand the above information. The above questions have been accurately answered. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payer and/or health practitioners. I authorize and request my insurance company to pay directly to Palmercare Chiropractic, any insurance benefits otherwise payable to me. I understand that I am responsible for all the charges. If the doctors are participating providers for my insurance, I understand that I am responsible for any co-payments, deductibles, or other charges in accordance with my plan. I authorize the use of this signature on all insurance submissions. Patient accounts with balances over 30 days old are subject to being charged an annual interest rate of 18% (1.5% monthly).

Signature of Patient (Or Parent) _____ Date_____

Patient Name _____ Date_____

Date of Accident_____ Time of Accident_____ □ PM □ AM

Was anyone else in the car with you? Y N Are they experiencing any discomfort? Y N

Please describe the accident in your own words: _____

_____

_____

_____

Were you the: □ Driver □ Front Passenger How many people were

□ Rear Passenger □ Pedestrian in the accident vehicle? _____

Road/Street Name _____

City/State _____

Nearest Intersection with road/street_____

Driving Conditions: □ Dry □ Wet □ Icy □ Other _____

Which direction were you headed? _____

Speed you were traveling? _____

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? □ Yes □ No

If yes, what type? □ Lap □ Shoulder

Was vehicle equipped with airbags? □ Yes □ No

If yes, did it/they inflate properly? □ Yes □ No

Did your seat have a headrest? □ Yes □ No

If yes, what was the position of the headrest?

□ Low □ Mid-position □ High

Make and model of other vehicle:

_____

Which direction was other vehicle headed? _____

Speed other vehicle was traveling? _____

Did your car impact another vehicle? □ Yes □ No

Did your car impact a structure? □ Yes □ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle?

□ Yes □ No

If yes, explain_____

Was Impact from?

□ Front □ Rear □ Left □ Right □ Other_____

At the time of impact were you:

□ Looking straight ahead □ Looking right

□ Looking left □ Looking down

□ Looking up

Were both hands on the steering wheel? □ Yes □ No

If no, which hand was on the wheel? □ Right □ Left

Was your foot on the brake? □ Yes □ No

If yes, which foot was on the brake? □ Right □ Left

Were you: □ Surprised by impact □ Braced for impact

Did the police come to the accident site? □ Yes □ No

Were there any witnesses? □ Yes □ No

Was a police report filed? □ Yes □ No

Was a traffic violation issued? □ Yes □ No

If yes, to whom? _____

Were you unconscious immediately after the accident? □ Yes □ No If yes, for how long? _____

Please describe how you felt immediately after the accident:

_____

_____

_____

Did you go to the hospital? □ Yes □ No

When did you go? □ Immediately after the accident □ Next day □ 2 days or more after the accident

How did you get to the hospital? □ Ambulance □ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____

_____

Treatment received_____

_____

X-rays taken_____

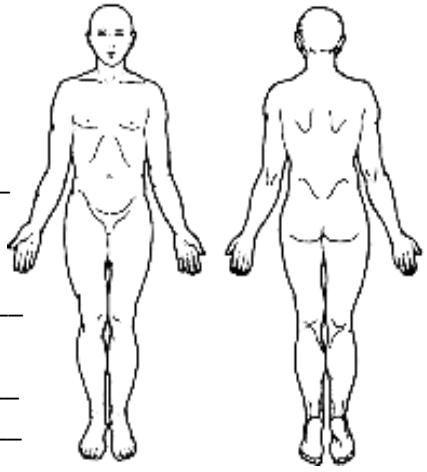
Have you been able to work since this injury? □ Yes □ No How many days have you missed? _____

Prior to the injury were you able to work on an equal basis with others your age? □ Yes □ No

If you have had any of the following symptoms since your injury, please specify:

□ Arm/shoulder pain	□ Feet/toe numbness	□ Neck pain
□ Back pain	□ Hand/finger numbness	□ Neck stiff
□ Back stiffness	□ Headaches	□ Shortness of breath
□ Chest pain	□ Irritability	□ Sleep difficulty
□ Dizziness	□ Jaw problems	□ Stomach upset
□ Ear buzzing	□ Leg pain	□ Tension
□ Ear ringing	□ Memory loss	□ Vision blurred
□ Fatigue	□ Nausea	

Is this condition getting progressively worse? □ Yes □ No □ Unknown



Mark an X on the picture where you continue to have pain, numbness, or tingling

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness

□ Aching □ Shooting □ Burning □ Tingling

□ Cramps □ Stiffness □ Swelling □ Other_____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation

Activities or movements that are painful to perform: □ Sitting □ Standing □ Walking

□ Bending □ Lying down

I certify that the above information is correct to the best of my knowledge.

Patient signature_____ Date_____

PALMERCARE
CHIROPRACTIC

IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORIZATION AND LIEN

To Whom It May Concern:

This Irrevocable Assignment of Benefits, Authorization and Lien (this "Assignment") is made by and between _____("Patient") and Palmercare Chiropractic ("Health Care Provider"). With this Assignment, and in consideration of treatment without having to render concurrent payment, Patient, hereby irrevocably transfers sets over and assigns to Health Care Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the Patient by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorney's fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to Patient or on Patients behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, personal injury protection benefits, third-party liability coverage, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patients favor as may be necessary to fully pay any and all financial obligations owed to the Health Care Provider by the Patient. This Assignment is to be a complete and current transfer of Patients right, title, and interest, separate from any statutory or contractual lien or claim to which the Health care Provider may also be entitled. Patient acknowledges that Health Care Provider has a substantial pecuniary interest in the enforcement of this Assignment.

The Patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Providers total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Health Care Provider any and all causes of action that Patient might have or that might exist in Patients favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates and appoints as Patients attorney-in-fact any officer of Health Care Provider, to prosecute said causes(s) of action either in Patients name or in the Health Care Providers name and Patient further authorizes the Health Care Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Health Care Provider, Patient hereby grants a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Health Care Provider. The Patient further agrees that the statute of limitations applicable to Health care Providers right to demand payment from the patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing.

If you have been in an automobile accident, you may be entitled to payment from your automobile insurance if you have medical expense benefits coverage. By signing this assignment of benefits form you are giving to your health care provider the right to receive some or all of that payment directly from your automobile insurance company.

If you have health insurance and your healthcare provider is in-network: as long as you provide information necessary to verify your health insurance coverage the healthcare provider may only bill the amount you owe for any copayment, coinsurance, or deductibles to your automobile insurance and you may be entitled to any remainder of your automobile insurance benefit.

If you do not provide information necessary to verify your health insurance coverage, do not have health insurance, or your healthcare provider is not in your health insurer's provider network: your health care provider may bill their full charges to your automobile insurance.

You may want to consult your insurance agent or attorney before signing or initialing this form. You are not required to sign/initial this form to receive care."

Patient hereby acknowledges that Virginia law imposes a lien in the amount of $750.00 upon Patients claim against the individual or entity whose negligence is alleged to have caused Patients injuries.

Notwithstanding the foregoing, the Patient agrees that until the Health Care Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due the Health Care Provider (including principal, interest, collection costs and attorney's fees) until fully paid. The Patient further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect payment, it may demand payments from Patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

Patient authorizes the Health Care Provider to release this Assignment and any information pertinent to Patients case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Health Care Provider as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of the services provided to Patient by said Health Care Provider.

In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect.

I have been presented with and had an opportunity to read the notice and understand that the execution of this AOB is not required by law.

Patient's Name:_____

Patient's Signature:_____ Date: _____

Attorney Name:

Attorney Signature: _____ Date: _____

Health Care Provider

Printed Name: Palmercare Chiropractic LLC

Signature: _____ Position: CFO Date: _____

PALMERCARE
CHIROPRACTIC

Notification to 3rd Party of Patient's Request Not to Bill Health Insurance

Date:

To whom it may concern,

_____ a patient of **Palmercare Chiropractic LLC** who, as an injured party in an accident involving your insured, has exercised their right under the HITECH-HIPAA Omnibus Rule of September 23, 2013 to restrict disclosure of their protected health information to their health insurance carrier, and has directed us to bill the medical expenses directly to you as the responsible insurance carrier.

In accordance with Virginia Code 38.2-2201, enclosed with this letter is this signed document by the patient requesting Palmercare Chiropractic LLC not to bill their health insurance, a final bill for services, the daily notes, and a **fully executed Assignment of Benefits (AOB) authorizing _____ to pay Palmercare Chiropractic LLC directly for medical expenses related to this claim.**

Please send payment directly to:

Palmercare Chiropractic LLC
20 Town Square, Ste 130
Lovettsville, VA 20180

Thanks for your cooperation in handling this claim in a timely manner. Please contact me at (703)421-2990 if you have any questions.

Sincerely,

Casey Holm, CFO
Palmercare Chiropractic LLC

Patient's Signature:_____

PALMERCARE
CHIROPRACTIC

Notification of Patient/Policyholder Request Not to Bill Health Insurance

Date:

To whom it may concern,

_____, a patient of **Palmercare Chiropractic LLC** and an automobile policyholder with _____ has exercised their right under the HITECH-HIPAA Omnibus Rule of September 23, 2013 to restrict disclosure of their protected health information to their health insurance carrier, and has directed us to bill the medical expenses directly to you as their Med-Pay carrier.

In accordance with Virginia Code 38.2-2201, enclosed with this letter is this signed document by the patient requesting Palmercare Chiropractic LLC not to bill their health insurance, a final bill for services, the daily notes, and a **fully executed Assignment of Benefits (AOB) authorizing _____ to pay Palmercare Chiropractic LLC directly for medical expenses related to this claim.**

Please send payment directly to:
Palmercare Chiropractic LLC
20 Town Square, Ste 130
Lovettsville, VA 20180

Thanks for your cooperation in handling this claim in a timely manner. Please contact me at (703)421-2990 if you have any questions.

Sincerely,

Casey Holm, CFO
Palmercare Chiropractic LLC

Patient's Signature:_____