

## 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 : 3<sup>rd</sup> Party \_\_\_\_\_ Claim # \_\_\_\_\_

Claim Adjuster: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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## 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  Rear Passenger  Pedestrian How many people were 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? \_\_\_\_\_

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

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 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:

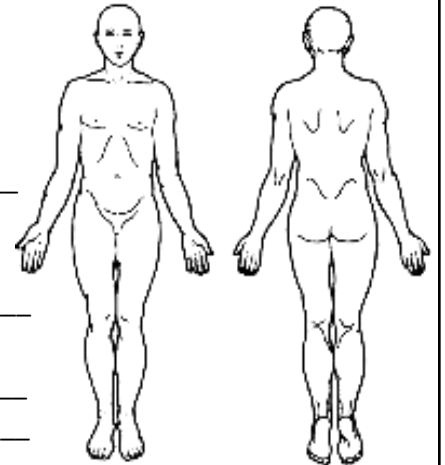
- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Feet/toe numbness    | <input type="checkbox"/> Neck pain           |
| <input type="checkbox"/> Back pain         | <input type="checkbox"/> Hand/finger numbness | <input type="checkbox"/> Neck stiff          |
| <input type="checkbox"/> Back stiffness    | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest pain        | <input type="checkbox"/> Irritability         | <input type="checkbox"/> Sleep difficulty    |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Jaw problems         | <input type="checkbox"/> Stomach upset       |
| <input type="checkbox"/> Ear buzzing       | <input type="checkbox"/> Leg pain             | <input type="checkbox"/> Tension             |
| <input type="checkbox"/> Ear ringing       | <input type="checkbox"/> Memory loss          | <input type="checkbox"/> Vision blurred      |
| <input type="checkbox"/> Fatigue           | <input type="checkbox"/> 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 \_\_\_\_\_



## **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 cause(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: \_\_\_\_\_



**Notification to 3<sup>rd</sup> 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  
126 S Main St Suite 110  
Fort Worth, TX 76104**

Thanks for your cooperation in handling this claim in a timely manner. Please contact me at (469) 702-2033 if you have any questions.

Sincerely,

Casey Holm, CFO  
Palmercare Chiropractic LLC

Patient's Signature: \_\_\_\_\_



**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.**

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Thanks for your cooperation in handling this claim in a timely manner. Please contact me at (469) 702-2033 if you have any questions.

Sincerely,

Casey Holm, CFO  
Palmercare Chiropractic LLC

Patient's Signature: \_\_\_\_\_