Motor Vehicle Accident Insurance – Information Request Form

This form must be filled out completely and returned to ARIZONA CHIROPRACTIC & HOLISTIC HEALTH CENTER before a claim can be submitted. Incomplete or illegible forms will not be accepted. Please print clearly in Blue or Black pen.

If this information is not provided within 48 hours
the patient will be financially responsible for all services provided and will be billed.

Patient Name: _______________ Date of Birth: _________ Date of Injury: ________ Approx. Time of Injury: _____
***Location of Injury:** Cross Streets: _______________________City: _____________ State: ______ Zip: __________

Your Auto Insurance Medical Payment Coverage:

On your automobile insurance, or the automobile insurance for the car in which you were a passenger, there may be coverage called "Med-Pay". This coverage is for any injuries that may have occurred to someone in the automobile. It will cover anything from an automobile accident that either was or wasn't your fault, to slamming you finger in the car door. Using this portion of the policy cannot raise your premium or affect your record in any way. In fact, this is exactly why you pay for "Med Pay" on your insurance policy. **Please give us a copy of you Proof of Insurance Card that is kept in your car.**

_______ Patient's Initials

Insurance Company ____
Address ____
Phone ____
Adjuster's Name: __________________________________ Policy: ____

Third Party Liability:

This is the insurance information form the person who was in the "other car". The information can be found on the Police Report. **Please give us a copy of the Police Report.**

Driver's Name: _________________________________ Policy Holder's Name: ____________________________
Insurance Name: ________________________________ Insurance Phone #: ______________________________
Policy #: _______________________________________ Claim #: ____
Adjuster's Name: ________________________________ Phone #: _______________________________________

Attorney Information:

Attorney Name: _________________________________ Phone Number: ___________________________________
Address: ____City: ____________________ State: ______ Zip: _________

Insurance Information for Personal Injury Cases:

Please provide us as much information as possible so you case can be set up to your financial advantage. In the State of Arizona, insurance laws read that you have the right to bill any insurance policy under which you have coverage. In the case of more than one insurance coverage, overpayment may occur. We only need to be paid once, so all overpayments will be reimbursed to you at the time you are release from care.

_______ Patient's Initials

Notice of Medical County Lien:

For our patients who have an auto accident or other personal injury claim.

In order to ensure that the parties liable for payment of your claim are fully aware that ARIZONA CHIROPRACTIC & HOLISTIC HEALTH CENTER is extending credit to you for your care in our care offices, we will be filing a medical county lien. All responsible parties, including you, will receive notification, via certified mail, that the lien has been filed. Once the payment has been received, the filing and releasing of this lien involves administrative costs of approximately $75.00. These costs will be added to your final bill.

Patient [or Parent/Guardian] Signature: ____ Date: __________

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION:

TO WHOM IT MAY CONCERN:

By signing this document, I hereby authorize, Douglas Morris, D.C., or any of his employers, employees or agents (collectively “Physician”) to release protected health information relating to my medical treatment by Physician, including information relating to the dates of my treatment and Physician’s charges for my treatment (collectively “PHI”), which is reasonably necessary for Physician to be compensated for services provided to me. I authorize the Physician to release my PHI to any person or entity responsible for paying for my care, to my attorneys (if I am being represented as a result of being injured in an accident) or as may be necessary to file a health care provider lien pursuant to A.R.S. 33-931, et seq.

This authorization shall remain in force until the later to occur of the completion of my medical treatment with the Physician and the Physician being fully paid for such medical treatment. I hereby retain the right to revoke the Authorization provided hereunder at any time; however, no such revocation shall be effective with respect to the Physician unless and until I provide written notice to the Physician of such revocation. I recognize that my PHI release by the Physician pursuant to this Authorization may be subject to re-disclosure by the recipient of such PHI, under certain circumstances where the recipient of my PHI is not subject to a physician-patient privilege or the limitations imposed upon the use or disclosure of PHI by the HIPPA regulations.

Patient [or Parent/Guardian] Signature: ____ Date: __________

AUTO/PERSONAL INJURY QUESTIONS

Please answer the questions below. **If you do not know an answer, do not answer the question.**

Your Position in Vehicle:

☐ Driver ☐ Rear Left Passenger ☐ Other:______________
☐ Front Passenger ☐ Rear Right Passenger
If Driver, were your hands on the steering wheel? ☐ Both ☐ Left ☐ Right

Your Vehicle Type:

☐ Car ☐ Station Wagon ☐ Large Truck ☐ Bus
☐ Van ☐ Pickup Truck ☐ Other: _______________

Area of Impact:

☐ Head-on ☐ Driver Side ☐ Left Rear ☐ Left Front
☐ Rear-end ☐ Passenger Side ☐ Right Rear ☐ Right Front
☐If Multiple impacts (Describe): ____

What was your vehicle doing at the time of accident?

☐ Stopped at intersection ☐ Making a right turn ☐ Accelerating ☐ Parking
☐ Stopped in traffic ☐ Making a left turn ☐ Slowing down ☐ Other:___________________
☐ Stopped at light ☐ Proceeding along

Body Position, etc:

Did you strike another vehicle?	☐ No ☐ Yes
Did another vehicle strike your vehicle?	☐ No ☐ Yes
Did you have a seat belt on?	☐ No ☐ Yes
Did you have a shoulder harness on?	☐ No ☐ Yes
Did you see the accident coming?	☐ No ☐ Yes
Were you surprised by the impact?	☐ No ☐ Yes
Were you braced for impact?	☐ No ☐ Yes
Were you rendered unconscious as a result of the accident?	☐ No ☐ Yes (Describe) _____________________
Did you feel pain immediately after the accident?	☐ No ☐ Yes (Describe) _____________________
Which places did you have pain?	☐ Head ☐ Neck ☐ Back ☐ Low back ☐ Shoulders ☐ Elbows ☐ Wrists ☐ Hands ☐ Hips ☐ Knees ☐ Ankles ☐ Feet
Was there any bruising?	☐ No ☐ Yes (Describe) _____________________
Where you leaning forward at time of impact?	☐ No ☐ Yes
Where was your head facing at the time of impact?	☐ Straight Ahead ☐ Left ☐ Right ☐ Behind
Did the airbag deploy?	☐ No ☐ Yes
Does your vehicle have headrests?	☐ No ☐ Yes
In relation to the back of your head, was your headrest set:	☐ Low ☐ Middle ☐ High
Did your seat break or bend?	☐ No ☐ Yes
Did your body strike the inside of your vehicle?	☐ No ☐ Yes (Describe) _____________________

Emergency Room?

Where did you go after the accident? ☐ Home ☐ Work ☐ Hospital ER ☐ Priv. Doctor ☐ Other:____________

How did you get there? ☐ Drove self ☐ Someone else ☐ Ambulance ☐ Other:______________

Did patient suffer any cuts or contusions? ☐ No ☐ Yes (Describe) ____

X-rays taken? ☐ No ☐ Yes (Regions) ____

Fractures? ☐ No ☐ Yes (Describe) _______________________________________

MRI/CT taken? ☐ No ☐ Yes (Regions) ____

Traumatic Brain Injury/Mild Traumatic Brain Injury / Post Traumatic Stress Disorder:

Nausea	☐ Occasional	☐ Sometimes	☐ Persistent
Vomiting	☐ Occasional	☐ Sometimes	☐ Persistent
Disoriented	☐ Occasional	☐ Sometimes	☐ Persistent
Amnesia	☐ Occasional	☐ Sometimes	☐ Persistent
Irritability	☐ Occasional	☐ Sometimes	☐ Persistent
Lethargy	☐ Occasional	☐ Sometimes	☐ Persistent
Cognitive Changes	☐ Occasional	☐ Sometimes	☐ Persistent
Vision Blurred	☐ Occasional	☐ Sometimes	☐ Persistent
Altered Breathing	☐ Occasional	☐ Sometimes	☐ Persistent
Loss of Consciousness	☐ Occasional	☐ Sometimes	☐ Persistent
Headache	☐ Occasional	☐ Sometimes	☐ Persistent
Migraine	☐ Occasional	☐ Sometimes	☐ Persistent
Personality Changes	☐ Occasional	☐ Sometimes	☐ Persistent
Ataxia/Walking Difficulty	☐ Occasional	☐ Sometimes	☐ Persistent
Deviated Gaze / Eye Movement	☐ Occasional	☐ Sometimes	☐ Persistent
Ringing in Ears	☐ Occasional	☐ Sometimes	☐ Persistent
Light Sensitivity	☐ Occasional	☐ Sometimes	☐ Persistent
Balance	☐ Occasional	☐ Sometimes	☐ Persistent

Work

Are you working at the present time? ☐ No ☐ Yes (Date last worked) ______________________

Have you missed any time from work? ☐ No ☐ Yes (Dates) ______________________

What position are you in at work most of the day? ☐ Standing ☐ Driving ☐ Walking ☐ Lifting ☐ Sitting ☐ Typing ☐ Other (Describe): ______________________

What limitations do you experience as a result of the injury? ☐ Standing ☐ Driving ☐ Walking ☐ Lifting ☐ Sitting ☐ Typing ☐ Other (Describe): ______________________

DOCTOR'S LIEN CONTRACT

This is the insurance information form the person who was in the "other car". The information can be found on the Police Report.

TO: ____ RE: ______________________________ DOI: ___________

____ ____

____ ____

____ ____

You are hereby instructed and authorized to pay directly to ARIZONA CHIROPRACTIC AND HOLISTIC HEALTH CENTER for all professional services rendered to me by this office.

The instruction to you is an assignment of my rights under medical coverage to the extent of this bill. Any sun of money paid under this assignment shall be credited to my account and I shall be personally liable for any unpaid accounts for hospital, diagnostic and consultant services. I hereby give an assignment of my rights and a lien on my case to the said doctor against any and all proceeds of any settlement, judgement or verdict which may be paid as a result of the injuries in connection therewith.

I understand that ARIZONA CHIROPRACTIC AND HOLISTIC HEALTH CENTER is withholding payment or collection efforts as a courtesy to me given that the treatment which I am receiving arises out of a claim for which insurance coverage exists whether through my own insurance company or the insurance company of a third party. I understand that I am personally, directly, and fully responsible to the said doctor for all medical bills submitted by him for services rendered to me. This agreement is made solely for the said doctor's additional protection and in consideration for this, awaiting payment.

Further, I do hereby authorize the above doctor's office to furnish the above attorney with a full report of his examination, diagnosis, etc. of myself in regards to the accident in which I was involved.

Patient's [or Parent/Guardian] Signature: ____

Patient's [or Parent/Guardian] Name Printed: ____

Date: ____

The undersigned being attorney of record for the above patient, dose hereby agree to withhold such sums any settlement, judgement, or verdict as may be necessary to adequately protect the staff doctor at ARIZONA CHIROPRACTIC AND HOLISTIC HEALTH CENTER. Furthermore, the undersigned agrees to notify ARIZONA CHIROPRACTIC AND HOLISTIC HEALTH CENTER immediately upon a change of legal representation in this matter to fully protect the interest of ARIZONA CHIROPRACTIC AND HOLISTIC HEALTH CENTER.

Attorney's Signature: _________________ Attorney's Name Printed: _______________________ Date: _________