PERSONAL INJURY PAPERWORK

Patient Financial Acknowledgement

You, on behalf of yourself and any patient for whom you are the parent or legal guardian, acknowledge and agree as follows:

If you or your dependent's personal injury claim involves a motor vehicle accident or slip and fall accident, and if you do not want Chiro One Wellness Centers to bill the applicable health insurer or automobile/premises insurer, you hereby authorize Chiro One Wellness Centers to pursue payment for services rendered to you or your dependent, as applicable, from any party involved in the accident or responsible for the injury.

If the personal injury claim involves a motor vehicle accident or slip and fall accident, and if you want Chiro One Wellness Centers to bill the applicable health insurer(s) and/or automobile/premises insurer(s), you hereby agree to cooperate with Chiro One Wellness Centers' billing and collection from the insurers and to provide everything required for the claim process, including, but not limited to, promptly:

1) reporting the claim to all applicable insurers (including my automobile or premises insurer and all other owners' and drivers' insurers);
2) providing all parties' names and addresses, their insurer names, addresses, and contact information (including the adjuster), their attorneys names, addresses, and contact information, and applicable claim numbers;
3) providing a copy of the police report; and
4) providing a copy of any correspondence received from the insurers regarding availability of benefits and/or coverage determinations.

Regardless of Chiro One Wellness Centers' agreement to pursue collection from applicable health and/or liability insurers, you agree that you will be primarily responsible for all charges owed to Chiro One Wellness Centers (other than those included in any pre-paid offer) for the services rendered to you or your dependent, as applicable, including attorney fees, court costs, and other expenses of collection, if incurred.

YOU HEREBY AGREE THAT THIS PATIENT FINANCIAL ACKNOWLEDGEMENT IS IRREVOCABLE.

_____	_____	_____, 202__
Name (*Printed*)	Signature	Date

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PERSONAL INJURY PAPERWORK

Insurance Company / Attorney Certification

Patient:
If you do not have all of the information requested below, please call your attorney or insurance adjuster and have this form completed for your next visit. Request an additional form if more space is needed.

My Automobile/Premises
Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax:_____ _____

Has the accident been reported? ☐Yes ☐No

Name of Adjuster:_____ E-Mail:_____

Insured Name: _____

Date of Accident: _____ Claim #: _____

Med Pay – How much is available? _____ What's left? _____

The Other Party's Automobile/Premises
Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax:_____

Has the accident been reported? ☐Yes ☐No

Name of Adjuster:_____ E-Mail:_____

Insured Name: _____

Date of Accident: _____ Claim #: _____

My Health Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

ID #: _____ Group #: _____

Insured Name: _____

Phone: _____

My Attorney: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____E-Mail:_____

Selection Required...

Chiropractor's Lien

To: Attorney(s) _____

Car Insurance: _____

Date of Injury: _____

Patient's Name: _____

I, _____, hereby authorize the above chiropractor to furnish you, my attorney(s), with a full report of the case history, examination, diagnosis, treatment, prognosis of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney(s), to pay directly to said chiropractor such sums as may be due and owing him/her for professional services rendered to me both by reason of the aforesaid accident and by reason of any other bills that are due and owing to his/her office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said chiropractor. I hereby further give a lien on my case to said chiropractor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney(s), 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 chiropractor for all professional bills submitted by him/her for services rendered me and that this agreement is made solely for said chiropractor's additional protection and in consideration of pending payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

_____ _____ _____

Name (*Printed*) Signature Date

_____

Address City State Zip

_____

Phone

I, _____, have reviewed the documents herein and I am notarizing this set of complete notes per the patient.

Attorney(s), please sign, date and return this Chiropractor's Lien to the chiropractor's office named above, keeping a copy for yourself.

The undersigned being attorney(s) of record for the above patient does herby agree to observe all of the terms and conditions of the above lien and agree(s) to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect the said chiropractor named above.

_____ _____ _____

Attorney(s)Name (*Printed*) Signature Date

Chiropractor's Lien is to be completed even if a lawyer is NOT involved with the PI case.
Email submittal to: PIWC@chiroone.net.

Authorization and Assignment of Benefits

In consideration of Chiro One Wellness Centers undertaking to render care, you, on behalf of yourself and any person for whom you are the parent or legal guardian, agree as follows:

Authorization for Release of Information

1. You authorize us to release any information concerning your or your dependent's treatment, as applicable, to any parties alleged to be liable for the injuries sustained, their representatives, and your representatives, including, but not limited to, any insurance company or attorney, for the limited purpose of seeking reimbursement for charges incurred by you or your dependent for treatment at Chiro One Wellness Centers.

2. You understand that:

- You are not required to sign this Authorization, and your treatment or payment for treatment is not affected by any refusal to sign this Authorization.
- You may revoke this Authorization at any time in writing to Chiro One Wellness Centers, but any revocation will not affect disclosures made or actions taken before the revocation is received by Chiro One Wellness Centers and it has had a reasonable opportunity to act on it.
- Federal privacy regulations will no longer apply to the information disclosed, and the information disclosed to Chiro One Wellness Centers may be re-disclosed to others.
- A copy of this Authorization is as valid as the original Authorization.
- You are entitled to a copy of this Authorization.

Irrevocable Assignment of Benefits and Right to Sue

3. You irrevocably authorize and assign to Chiro One Wellness Centers the right to receive direct payment from any parties liable for the injuries sustained and their representatives. You further authorize the endorsement of your name to any draft or check containing your name to which you are legally entitled.
4. In addition to the charges incurred for treatment, you agree to be financially responsible for any legal fees and court costs incurred by us to collect any outstanding balance owed.
5. In the event any parties or their representatives obligated to issue payments to you or your dependent for injuries sustained, refuse to honor their obligations, you hereby irrevocably assign and transfer to Chiro One Wellness Centers the cause of action that exists in your favor against any such party, insurer, or attorney and authorize us to prosecute said action either in our name or your name. You agree to pay us whatever amounts we do not collect from said parties, insurers, or attorneys (whether it be all or part of what is due) and that we shall have no duty to pursue collection from any other party prior to pursuing collection from you.
6. You agree that we may assert a healthcare services lien, as provided by law.

_____	_____	_____
Name (*Printed*)	Signature	Date

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PERSONAL INJURY PAPERWORK

Personal Injury Questionnaire – Motor Vehicle Accident

Please describe how your injury occurred:

_____

_____

_____

Did the accident occur while you were at work? If yes, please indicate your employer's name:	☐Yes ☐No _____
Did another person cause the accident? If, yes, who:	☐Yes ☐No _____
If you responded "yes" to either of the above questions, do you intend to pursue a personal injury claim?	☐Yes ☐No
Where did the accident occur? (Please include city, state and zip code)	_____ _____
What was your involvement? If you were a vehicle passenger, where were you seated?	☐Driver ☐Passenger ☐Cyclist ☐Pedestrian ☐Front ☐Right-rear ☐Left-rear
From what direction was the impact?	☐Front ☐Rear ☐Left Side ☐Right Side
What were your approximate speeds at the time of impact?	You: _____mph Others: _____mph
What were the weather condition(s) at the time of the injury?	☐Dry ☐Wet ☐Snow / Ice ☐Other: _____
Were you moving or stopped?	☐Moving ☐Stopped
If your vehicle was shoved, in what direction did it move?	☐Forward ☐Backward ☐Sideways
If you were shoved, in what direction did you move?	☐Forward ☐Backward
Did any part of your body hit the interior of the vehicle or the ground? If so, which part of your body:	☐Yes ☐No ☐Windshield ☐Side door ☐Side window ☐Other: _____ ☐Chest ☐Head ☐Chin ☐Face ☐Right knee ☐Left knee ☐Other: _____
Were you holding on to the steering wheel?	☐Yes ☐No
Did the vehicle go into a spin/roll as a result of the impact? If yes, please explain:	☐Yes ☐No _____
At the point of impact, where did you experience pain? *(Please be specific)*	_____ _____
Immediately following the accident, which of the following best describes your state? If you lost consciousness, how long were you unconscious?	☐ Conscious ☐ Dazed ☐ Unconscious _____
Did you go to the hospital? If yes, when? How did you get to the hospital? If by ambulance, did the ambulance attendants place you in any of the following:	☐Yes ☐No ☐ Immediately ☐Next Day ☐Other: _____ ☐Ambulance ☐ Other: _____ ☐ Neck brace ☐ Back brace ☐Other: _____
If you were admitted into the hospital, please answer the following… Name of hospital: Name of doctor: Diagnosis: Treatment received:	_____ _____ _____ _____
Did you have any X-Rays taken at the hospital?	☐Yes ☐No
Did you have any other imaging taken at the hospital (MRI/CT)?	☐Yes ☐No
Were there any other medical supplies or medications given? If yes, what?	☐Yes ☐No _____
Have you had any similar problems before? If yes, please explain:	☐Yes ☐No _____
Have you lost any days of work from this injury? If yes, please list date(s):	☐Yes ☐No _____

_____	_____	_____
Name (*Printed*)	Signature (*Patient/Parent/Guardian*)	Date
_____	_____	_____
Witness Name (*Printed*)	Signature	Date

HIPAA AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date:_____

Clinic Location(s) Authorized to Make the Requested Disclosure: _____

Patient Name: _____ **Date of Birth:** _____

Address: _____ **Phone:** _____

I authorize the release of my medical information specified below from the above listed Chiro One Wellness Center Clinic Location ("Chiro One") to:

Name of Person or Entity whom Chiro One May Make the Requested Disclosure:

_____

Address:

_____

Phone: _____ **Purpose for Disclosure:** _____

Date Range: From _____ to _____.

RECORDS TO BE RELEASED

☐ Entire Medical Record/Complete Patient File

If you are not requesting the entire medical record/complete patient file, please select or list specific documents to be requested **(check all that apply)**:

☐ Patient Intake Paperwork

☐ Patient Signed Consents

☐ X-Ray Films

☐ Physician Notes

☐ Correspondence

☐ Examinations/Consultations

☐ Treatment Plans/Prescriptions

☐ Reports

☐ Bills/Invoices/Payments

☐ Other: _____

(Please list.)

HIPAA AUTHORIZATION TO RELEASE MEDICAL INFORMATION

METHOD OF DELIVERY

(Please select only one.)

☐ U.S. Mail ☐ Fax*

☐ Email* ☐ Other: _____

***Records Disclosed by Email or Fax**: I authorize the above requested records to be disclosed electronically to the following email address or fax number:

Email or Fax Number: _____ **Patient Initials:** _____

Email or Fax Acknowledgement:

I, the undersigned, warrant that I am the only person or entity that has access to the email address or fax number as provided above.

Name: _____ **Signature**: _____

(*Person or Entity Receiving Email or Fax)*

I understand that:

- I am not required to sign this Authorization, and my medical provider may not condition treatment, payment for treatment, enrollment or eligibility for benefits on whether I sign this Authorization.
- This Authorization will expire one year from the date of signature below. I may revoke this Authorization at any time in writing to the healthcare provider, except to the extent Chiro One has already relied on my authorization, and Chiro One has not had a reasonable opportunity to act when it receives the revocation.
- Federal privacy regulations will no longer apply to the information disclosed, and the information disclosed to the recipient may be re-disclosed to others.
- A copy of this Authorization is as valid as the original Authorization.
- I am entitled to a copy of this Authorization.

_____ _____

Patient Signature Date

_____ _____

Printed Name Relationship to Patient