WORKERS COMPENSATION PAPERWORK

Patient Financial Acknowledgement

I, _____, state that by signing this Patient Financial Acknowledgement, I acknowledge and agree as follows:

- If my case involved a motor vehicle accident, and in the event that I do not wish to bill my auto insurance carrier, I hereby authorize Chiro One Wellness Centers to pursue any payment from the other party involved in the accident. I will be financially responsible for any legal fees incurred by Chiro One for collection efforts of delinquent balances on my and/or my dependent's(s') account(s).
- Pursuant to billing the other party's insurance, I have provided everything needed for the claim process, (i.e., an open claim with the other party's insurance company, a correct claim number associated with the specific claim and a phone number with the name of the adjuster handling the claim). Any paperwork I receive from the other party's insurance company, I will submit to the office providing treatment.
- Following the completion of the corrective care provided, if there is no reimbursement/payment from the other car insurance regardless of cause, I will be financially responsible for the entire cost of my corrective care treatment.

I HEREBY AGREE THAT THIS PATIENT ACKNOWLEDGEMENT IS IRREVOCABLE.

_____	_____	_____
Name (*Printed*)	Signature	Date

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WORKERS COMPENSATION PAPERWORK

Patient Employer Coverage Sheet

Patient: Please fill out completed. If you do not have all of the information at this time, please call your Adjuster and have this form completed for your next visit.

Patient Name: _____

WC Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

WC Insurance Carrier: _____

Date of Incident: _____ WC Claim #: _____

Has the incident been reported? ☐ Yes ☐ No

Name of Adjuster handling the WC claim: _____

Patient Health Insurance Coverage Sheet

Health Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

ID #: _____ Group #: _____

Insured Name: _____

Phone: _____

chiroone wellness centers

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 case.
Email submittal to: PIWC@chiroone.net.

WORKERS COMPENSATION PAPERWORK

Assignment of Benefits
-IRREVOCABLE-

Patient: _____ Date: _____

In consideration of your undertaking to render care, I agree to the following:

Release of Information

1. 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 at your treatment facility.

Right to Receive Payment

2. **I authorized and assign to you,** the medical provider, the right to receive direct payment from my attorney or any insurance company who may become obligated to pay me any sums. I further authorize the endorsement of my name to any draft or check containing my name to which you are legally entitled.
3. **I am financially responsible for any legal fees incurred by Chiro One for collection** efforts of delinquent balanced and/or my dependent's (s') account(s).

Assignment of Right to Sue

4. In the event any insurance company or attorney, obligated by contractual agreement to issue payments to me for your service charges, refuses to pay upon demand by you, I hereby assign an transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to prosecute said action either in my name or your name as you otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from said insurance proceeds (whether it be all or part of what is due) shall be paid by me.
5. I also assign to you, the medical provider, and grant the right of lien against any and all claims against any third party, whose negligence may have caused my injury, including their insurance, up to the amount of the bill for treatment.
6. I waive the Statute of Limitations regarding my chiropractor's right to recover from me directly.
7. I hereby direct my attorney to cooperate, assist and not interfere with you, the medical provider, in recovering any MedPay benefits that I may be entitle to.

I HEREBY AGREE THAT THIS PATIENT ACKNOWLEDGEMENT IS IRREVOCABLE.

_____ _____ _____
Name (*Printed*) Signature Date

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WORKERS COMPENSATION PAPERWORK

Non-Motor Vehicle Questionnaire

Please describe the incident/injury in your own words:

_____

_____

_____

Where did the incident occur? *(Please include city, state and zip code.)*	_____ _____
Was there anything you feel caused the injury? If yes, please describe (ex: wet floors).	☐Yes ☐No _____
Did anyone witness your injury? If yes, who?	☐Yes ☐No _____
Did you report your injury to anyone? If yes, who?	☐Yes ☐No _____
Was the injury report written or verbal?	☐Written ☐Verbal
Have you retained an attorney? If yes, please include phone number, city, state, & zip code.	☐Yes ☐ No _____
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	Date
_____	_____	_____
Witness Name (*Printed*)	Signature	Date

HIPAA AUTHORIZATION TO RELEASE CHIRO ONE RECORDS

Date:_____

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

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

Address:_____ **Phone:** _____

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

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

_____

Address:

_____

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

Records Date Range: From_____to_____.

RECORDS TO BE RELEASED

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
- ☐ Other: _____ *(Please list.)*
- ☐ Examinations/Consultations
- ☐ Treatment Plans/Prescriptions/Treatment Recommendations
- ☐ Reports
- ☐ Bills/Invoices/Payments
- ☐ Financial Commitments

HIPAA AUTHORIZATION TO RELEASE CHIRO ONE RECORDS

METHOD OF DELIVERY

(Please select only one.)

☐ U.S. Mail ☐ Fax*

☐ Email* ☐ Other: _____

***Records Disclosed by Email or Fax**: You 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:
You, the undersigned, warrant that you are 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)*

You understand that:

- The information in my record may contain information regarding sexually transmitted diseases or HIV/AIDS. Your record may also contain information about mental health services or treatment for alcohol and/or drug abuse.
- You are not required to enter into this Authorization, and Chiro One may not condition treatment, payment for treatment, enrollment or eligibility for benefits on whether you sign this Authorization. Chiro One is allowed by law to disclose information regarding treatment, payment, or health care operations without my consent.
- This Authorization will expire one year from the date of signature below. You may revoke this Authorization at any time in writing to Chiro One, except to the extent Chiro One has already relied on your authorization and 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.
- You are entitled to a copy of this Authorization.

_____ _____
Patient Signature Date

_____ _____
Printed Name Relationship to Patient