WILLIAMS
CHIROPRACTIC & DECOMPRESSION CENTER P.C.

Automobile Accident Questionnaire

Date of Accident: _____ Time of Day:_____
Please explain in detail:_____
_____
_____
Name of driver in your vehicle: _____
Name of driver in other vehicle:_____

Type of vehicle you were driving:_____
How many passengers in your vehicle?:_____Other vehicle?:_____

Were police notified? □YES □NO Citations given? □YES □NO To whom?_____

Did your body strike any part of the vehicle? □YES □NO If yes, where?:_____
Were you knocked unconscious? □YES □NO If yes, for how long?:_____

Were you struck from: □BEHIND □FRONT □PASSENGER SIDE □DRIVER SIDE

You were: □DRIVER □PASSENGER □FRONT SEAT □BACK SEAT
Were you wearing seat belt? □YES □NO
Air Bag Deploy? YES NO

What position was your body at the time of impact?: □STRAIGHT □ROTATED RIGHT OR LEFT □OTHER

When did you feel pain? □IMMEDIATELY □LATER THAT DAY □NEXT DAY
Where did you feel pain?_____
Where were you taken after the accident?_____
What treatment was given, if any?: _____
_____
Did you consult any doctor after the accident? □YES □NO If so, who?:_____
Diagnosis given?:_____
Treatment?:_____

Have you ever had any complaints in the same area before? □YES □NO
If yes, explain:_____
What were the complaints?:_____

Have you ever had an accident claim before? □ YES □NO
Are your work activities restricted as a result of this accident? □YES □NO

Since this injury, are your symptoms: □IMPROVING □ GETTING WORSE □THE SAME

Patients Signature:_____ Date:_____
Signature of Parent or Guardian:_____ Date:_____

Office Policies

Personal Injury cases are accepted in our office. All personal injury cases, whether car or home accidents, must provide necessary information regarding your personal car insurance, the “at fault” insurance, your commercial health insurance, as well as the accident report, and attorney name and contact information if one has been retained.

The personal car insurance is needed because most individuals have medical benefits (usually called “Medpay” or” PIP”) included in their automobile policies and some do not even realize it. If these benefits are available on your policy, our office requires that you use them in the event that your injuries are as a result of an automobile accident. The following outlines why we require Medpay or PIP be filed:

1. Medpay and PIP are exactly like health insurance – using either form of coverage does not cause your rates to go up. However, if your rates are increased it is not because of the medpay was filed. It is most likely because: (a) the accident was determined by the insurance company to be your fault, (b) you received a police citation or ticket, and (c) you have been involved in numerous reported auto accidents within a brief period of time and are therefore considered “high risk”.
2. Filing your Medpay or PIP does not relieve the “at Fault” party from having to pay in full for your loss. Filing Medpay or PIP does not relieve the other party from being held responsible for payment. If the “at fault” driver’s liability insurance refuses to make payment on your medical bills for whatever reason, filing your Medpay/PIP will help ensure that you are not left to pay these expenses out of pocket.
3. We do not charge for filing your Medpay or PIP.

As long as Williams Chiropractic & Decompression Center, P.A. is filing my Medpay/PIP and, the insurance company is continuing to cover the charges accrued, collection of payment at time of service will be waived.

If overpayment on my account is made, Williams Chiropractic & Decompression Center, P.A. will refund the difference. I clearly understand and agree that all services rendered to me are charged directly to me, thus, I am personally responsible for payment in full.

Signature below of patient/Guardian indicates that you have read and accept above provisions.

Signature of Patient or Guardian:_____

Date:_____

CONTRACTUAL LIEN

I hereby authorize and direct you, the insurance company, and/or my attorney, to pay directly to Williams Chiropractic Clinic, PC such sums as may be due and owing this office for services rendered to me, both by reason of accident, of illness and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, liability benefits, health and accident benefits, workmen's compensation benefits, or any other insurance benefits obligated reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office.

I hereby further give a lien to said office against any and all insurance named hereto, and any and all proceeds of any settlement, judgment or verdict that may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due the office for their services. I further understand and agree that this assignment, lien and authorization does not contribute any consideration for the office to away payments and they may demand payment from me upon rendering services at their option. I authorize this office to release any information pertinent to my case to any insurance company or attorney to facilitate collection under this assignment, lien and authorization.

I agree that the above mentioned office be given power of attorney to endorse my name on any and all checks for payment of my doctor bill.

I further understand and agree, that is this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this office for all costs of such collection efforts including, but not limited to all court costs and all attorney fees.

I fully understand that upon settlement, by signing this agreement and without exception, I cannot use G.S. 44.49, Supplement of G.S. 44-50. The above general statues mention recoveries for personal injury. I acknowledge my acceptance by my signature, which is witnessed to waive use of the above general statutes. Please acknowledge this letter by signing below.

I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payments on my current balance.

By signing below, I acknowledge I have read, understood and agree to the above provisions.

Patient Name (please print):_____
Patient Signature:_____ Date:_____

Parent or Guardian Name (please print):_____
Parent or Guardian Signature:_____ Date:_____

Witness Signature:_____ Date:_____

ELECTION TO NOT FILE HEALTH INSURANCE CLAIM

To Whom It May Concern:

Upon my inquiry, the staff of Williams Chiropractic and Decompression Center, P.C. has advised me that the cost of my treatment may be covered in whole or part by my own health insurance. The staff has informed me that if I file on my own health insurance, I will be responsible for paying deductibles and co-payments, and these payments will be due as treatment is received. The staff has provided me with factual information regarding the various forms of reimbursement available to me and has answered my questions.

After giving due consideration to my options, I have decided that I **DO NOT** wish to file any claims on my health insurance. I hereby instruct the staff to refrain from sending bills and treatment records to my health insurance carrier or benefit plan. I authorize the staff to send bills and treatment records only to potential sources of payment other than my health insurance.

I understand that the clinic will rely on my decision and render treatment based on the assumption that payment will be received from sources other than my health insurance. I will not be expected to pay deductibles or co-payments. I understand that if third-party payers are billed, they will be billed at the clinics usual rates rather than discounted rates that may apply to in-network providers.

I understand that contractual and statutory deadlines may present me from filing on my health insurance at a later date. The decision I am making today not to file on my own health insurance is irrevocable.

I understand that I remain personally liable for the reasonable value of the treatment rendered to me by the clinic.

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Williams Chiropractic Clinic, PC
Office Policies

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The personal car insurance is needed because most individuals have medical benefits (medpay or PIP) included in their automobile policies and some do not even realize it. If these benefits are available on your policy our office requires you to use them in the event you have been injured in an automobile accident.

Here are several reasons why we require your Medpay or PIP to be filed:

1. Medpay and PIP are exactly like health insurance – using either form of coverage does not cause your rates to increase.
   However, if for some reason, your rates do increase it is not because medpay was filed. It is most likely because: (a) The accident was determined by the insurance company to be your fault, (b) you received a police citation or ticket, or (c) you have been involved in numerous reported auto accidents within a brief period of time and there are considered to be "high risk".

2. Filing your medpay does not relieve the "at fault" party from having to pay in full for your loss. Filing medpay or PIP does not relieve the other party from being responsible for payments. If the "at fault" driver's liability insurance refuses to make payment on your medical bills for whatever reason, filing your medpay/PIP will help ensure that you are not left to pay medical bills our of your own pocket.

3. We do not charge for filing your Medpday or PIP.

As long as Williams Chiropractic, PA is filing medpay/PIP, and the insurance company is continuing to cover the charges accrued, collection of payment at time of service will be waived. If overpayment on my account is made, Williams Chiropractic, PA will refund the difference. I clearly understand and agree that all services rendered to me are charged directly to me, thus I am personally responsible for payment in full.

X_____ Date_____
SIGNATURE OF PATIENT OF GUARDIAN INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE OFFICE POLICY

Required Personal Injury Form

At Fault Information
Insurance Company Name:_____
Claim # _____
Adjuster Name: _____
Phone Number:_____

Personal Auto Information (MedPay/PIP)
Insurance Company Name:_____
Claim # _____
Adjuster Name: _____
Phone Number:_____

Attorney Information
Name_____
Phone Number:_____

Health Insurance Information
NEED COPY OF INSURANCE CARD

Accident Information
NEED COPY OF ACCIDENT REPORT

I understand it is my responsibility to supply Williams Chiropractic Clinic, P.C. with the above information by my second visit in order to continue receiving care on credit. If this information is not presented by my second visit I agree to pay for my visits until this information is provided. I also understand it is my responsibility to call my insurance company to open my MedPay claim after my first visit.

Patient Signature:_____ Date:_____
Parent or Guardian Signature:_____ Date:_____

Witness Signature:_____ Date:_____