

AUTOMOBILE ACCIDENT - HISTORY

NAME: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

AGE: _____ Date Of Birth: _____ Sex: F () M ()

Date of Injury: _____ Time of injury: _____

State how the accident happened: _____

Were you driving? _____ Was it your car? _____ If not, who's? _____

Passenger? Front _____ Back _____ Left side _____ Right side _____

Seat belt on? _____ Shoulder harness on? _____ Were you rotated in seat? _____

Did you hit any part of your body during the collision, for example, head on dash? _____

If yes, which part and how? _____

Where were you taken after the accident? _____

Were you hospitalized? _____ If yes, where and for how long? _____

Did you receive care from any other health care specialist? _____

If yes, who and how long? _____

Did you miss any time from work due to your accident? Yes () No ()

If yes, please list dates: _____

At the time of the accident where did you feel pain? _____

What are your current symptoms? _____

Have you ever been injured in a similar manner? _____ If yes, how and when?

INSURED NAME (IF DIFFERENT): _____

INSURANCE CO: _____ ADDRESS: _____

PHONE #: _____ ADJUSTER: _____

DATE OF INJURY: _____ CLAIM#: _____ POLICY#: _____

ATTORNEY: _____ PHONE#: _____

ADDRESS: _____

BILLERICA CHIROPRACTIC OFFICE, P.C.

IRREVOCABLE ASSIGNMENT OF BENEFITS

INSURANCE CARRIER - ATTORNEY: _____

ADDRESS: _____

In consideration of receiving chiropractic services from Billerica Chiropractic Office, P.C., having its usual place of business at 25 Bridge Street, Billerica MA 01821, I hereby assign and transfer to Billerica Chiropractic Office, P.C. such sums as may be due Billerica Chiropractic Office, P.C. upon receipt by the above named insurance company or attorney of an itemized statement for chiropractic services rendered to me by said chiropractic office.

It is further understood and agreed that payment of said itemized statement by the above named insurance carrier or attorney as herein directed by me shall be considered the same as if paid by the above named Insurance carrier or attorney directly to me.

PATIENT SIGNATURE: _____ DATE: _____

GUARDIAN SIGNATURE: _____ DATE: _____

PRINTED NAME

ADDRESS

CITY, STATE, ZIP

DATE OF INJURY

CLAIM NUMBER

Financial Responsibility for Personal Injuries

- **It is YOUR responsibility to provide accurate information concerning your injury within 3 days of starting care at this office. If this information is not provided, you will be presented with a bill, which must be paid in full at that time.**
- **In Massachusetts we are a no-fault insurance state. Based on that, you are entitled to 100% coverage for treatment and wage loss under what is known as PIP (personal injury protection) insurance. The maximum benefit for an automobile accident is usually \$2000.00 per person.**
- **After your \$2000.00 is exhausted your health insurance will be billed at that time.**
- **We will file all the necessary paperwork to process this claim. Although, it is your responsibility to know where you stand at all times concerning this bill at Billerica Chiropractic.**
- **On a monthly basis you will receive a current statement to keep you informed of the services rendered at this office.**
- **Any payment for services that the company denies or refuses to cover will become your responsibility.**
- **It is very important that you follow your plan of care so that you do not jeopardize the validity of your injuries.**

I have read and understand this policy.

Patient signature: _____

Date: _____

Guardian signature: _____

Date: _____

**Authorization for
Release of Records &
Physician's Lien**

TO: ATTORNEY/INSURANCE CARRIER

FROM: Billerica Chiropractic Office, P.C.
25 Bridge Street
Billerica, MA 01821
(978) 667-1932
www.billericachiro.com

RE: PATIENT RECORDS AND DOCTOR'S LIEN

Ref Patient Name: _____ DOB: _____

RELEASE OF RECORDS: I do hereby authorize Billerica Chiropractic Office to furnish you, my attorney/insurance carrier, with a full report of the doctor's case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident /illness which occurred/began on _____ (date of accident or injury).

LIEN ON SETTLEMENT: I hereby give a Lien to Billerica Chiropractic Office on any settlement, claim, judgment, or verdict as a result of said accident / illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to Billerica Chiropractic Office such sums as may be due and owing my doctor for service rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect Billerica Chiropractic Office adequately.

IRREVOCABLE LIEN: I understand that this Lien shall be irrevocable either by myself or any other agent that represents me; that in the event another attorney is substituted in this matter, the new attorney shall honor this lien as inherent to the settlement and enforceable upon the case as if it was executed by him.

RESPONSIBILITY FOR PAYMENT: I fully understand that I am directly and fully responsible to Billerica Chiropractic Office for all chiropractic bills submitted by the doctor for service rendered me, and that this agreement is made solely for Billerica Chiropractic Office's additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

A photocopy or facsimile of this executed instrument shall be considered as valid as the original.

Patient Signature: _____ Dated: _____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately Billerica Chiropractic and to withhold such sums from any settlement, judgment or verdict, after subtraction of attorney fees and expenses, as may be necessary to adequately protect the said provider and Billerica Chiropractic Office.

Auth. Signature: _____ Dated: _____

NOTICE: Please date, sign, and return the original to our office as soon as possible.
(Reply envelope attached)

