C.A.R.E. Health & Wellness Center

Erik Heyliger, DC, DAAMLP, CSCS
Chiropractic Physician/Strength & Conditioning Specialist
CT Lic # 1807/ Tax ID # 27-2431950

810 BEDFORD ST. Ste # 1
STAMFORD, CT 06901
(203) 295-3484
FAX (203) 295-3484

RECORD RELEASE AUTHORIZATION

NAME _____

ADDRESS _____

PHONE O _____ H _____

SS# _____-____-_____ D.O.B._____/_____/_____

I HEREBY authorize the attending doctor to release any information concerning my examination or treatment.

PATIENT SIGNATURE _____

Attorney Name/ Address

Insurance Company Name/Address

__Male
__Female

Patient's Relationship to Insured
__Self __Spouse __Child Other

Was condition related to:
Patient's employment __Yes __No
Auto accident __Yes __No
Policy Holder or Employer_____
Insured_____ SS# _____
POLICY NO._____ CLAIM NO._____
Has patient ever had same or similar symptoms? __Yes __No Dates of Disability __Total __Partial From_____ Through_____
Return to work date_____
DIAGNOSIS: (ICD-9CM) NEW DIAGNOSIS ___ ___ ___ UPDATE ___ ___ ___
1._____ 3._____
2._____ 4._____

(Please Print)

Today's date:

MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Health Insurance Company:	Policy#	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F
Auto Insurance Company:	Policy#				

Street address:	Social Security no.:	Home phone no.: ( )

City:	State:	ZIP Code:

Please describe the accident in your own words:

7. Where did the accident occur? City/Town: State:

8. Date of accident: Time: ☐ AM ☐ PM

9. Were you the: ☐ driver ☐ passenger ☐ pedestrian

10. If passenger, were you in the: ☐ front seat ☐ right rear seat ☐ left rear seat

11. What was the weather at the time of the accident? ☐ dry ☐ wet ☐ icy

12. Did any other part of your body hit the interior of the vehicle? ☐ Yes ☐ No

13. Immediately after the accident were you: ☐ conscious ☐ dazed ☐ unconscious

14. Were you wearing a seat belt? ☐ Yes ☐ No Did you brace yourself? ☐ Yes ☐ No

15. What part/s of your body was injured?

16. Did you go to the hospital? ☐ Yes ☐ No Which hospital?

17. If yes, when? ☐ right after the accident ☐ next day ☐ other:

18. If yes, how did you get there? ☐ ambulance ☐ other:

19. Any medication or treatment given? ☐ Yes ☐ No Type of Treatment/Medication: X-rays? ☐ Yes ☐ No

20. Was any doctor consulted after your accident? ☐ Yes ☐ No
Name of doctor and treatment:

21. Have you had any similar problems before? ☐ Yes ☐ No
If yes, explain:

22. Have you lost any days of work/school from this injury? ☐ Yes ☐ No

23. What type of work do you do?

24. Have you hired an attorney? ☐ Yes ☐ No

25. Name of Attorney?

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize C.A.R.E. Health and Wellness Center or Insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Doctor's Lien

To: Attorney / Insurance Carrier

_____

_____

_____

_____

_____

Doctor

Dr. Erik Hevliger

Chiropractor

810 Bedford St, Suite 1

Stamford, CT 06901

(203)295-3484

Re: Patient Records and Doctor's Lien

I do hereby authorize the above doctor to furnish you, my attorney / insurance carrier, with a full report of his/her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/ illness which occurred/ began on _____.

I hereby give a lien to said doctor on my portion of the proceeds of 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 said doctor such sums from my portion of the case proceeds as may be due and owing him/her for service rendered to me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him/her for services rendered me, and that this agreement is made solely for said doctor's additional protection and in consideration of his/her awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

Dated: _____ Patient's signature: _____

Patient's Name: _____

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 not agree to honor the same to protect adequately said above named doctor.

Dated: _____ Authorized Signature: _____

NOTICE: Please date, sign, and return one copy to doctor's office at once. Keep one copy for your records. Reply envelope attached.