**Patient Name:**_____
**Date of Accident**_____

## AUTO ACCIDENT INSURANCE INFORMATION

**(Please provide the following information to our office about your claim. With this information we will be able to forward your claims to the appropriate insurance company.)**

LIABILITY INSURANCE: Claim No._____

Insurance Company Name_____

Address_____

City_____State_____Zip Code_____

Adjuster's Name_____

Phone No._____Fax No._____

MEDPAY INSURANCE: Claim No._____

Insurance Company Name_____

Address_____

City_____State_____Zip Code_____

Adjuster's Name_____

Phone No._____Fax No._____

PATIENT'S HEALTH INSURANCE (Please provide a copy of the insurance card)

Patient's Name_____Date of Birth_____

Insurance Company_____

Policy Number_____Group No._____

Send Claims To_____

_____

**Askeland Chiropractic & Acupuncture**

## AUTOMOBILE ACCIDENT HISTORY

Name_____Address_____

Sex:____ Age:____ Driver's License #:_____

### General Symptoms:

Did you hit any part of your body during the collision (head or chest on steering wheel or dash board?____ If Yes, which part and how?_____

_____

Did you become/have: **Confused** **Disoriented** **Light-Headed** **Dizzy**
**Nauseous** **Blurred Vision** **Ringing in the ears**

Do you still have any symptoms?_____ Which ones?_____

Are you currently suffering from any of the following?
**Restlessness** **Irritability** **Poor Concentration** **Memory Loss** **Insomnia**

Did you go to a hospital?_____ If Yes, which hospital?_____
How did you get to the hospital?_____
What parts of your body were x-rayed at thehospital?_____
What did the hospital do for your injuries?_____
Were you bleeding at the time of the accident?_____
What bruises did you sustain during this accident?_____
Did you receive care from any other medical professional?_____ Name?_____
What type of care were you given and for how long?_____
Where did you feel the pain?_____
What are your current symptoms?_____
Have you ever been injured in a similar manner?_____ If Yes, how and when?_____
_____

### Accident History:

Date:_____ Time:_____
State how the accident happened in your own words:_____
_____
_____

Were you Driving? **Yes** **No** Were you a passenger in the: **Front** or **Back**
Were you on the: **Right Side** or **Left Side**
Were you looking straight ahead? **Yes** **No** If No, then where were you looking?_____
Was it your car? **Yes** **No** If Not, Whose? _____

Other People in car: Name and Address:
1)_____ Address_____
2)_____ Address _____
3)_____ Address _____

Was your car stopped at the time of impact? **Yes No**
If Yes, was the driver's foot also on the brake? Yes No
If No, then estimate the speed of the vehicle you were in: mph

If your vehicle was moving at the time of impact, was it:
slowing down? **Yes No** Accelerating? **Yes No**
traveling at a steady rate of speed? **Yes No**

Were you wearing a seat belt? **Yes No** Was the shoulder harness on? **Yes No**
Did you receive any injury or bruise from the seat belt? **Yes No**
If yes, then describe the injury:_____

How far is the top of the headrest or reattack from the top of your head:_____inches above or below

Was it: **Daylight Night Dusk Dawn**
Were you tired? **Yes No** Were you awake? **Yes No**
How long had you been in the car?_____
Where were you prior to the accident?_____
What were the weather conditions?_____
What was the posted speed limit?_____ mph How fast were you going? mph_____

Type of road? **Two Lane Four Lane Gravel Tar**
Did the collision occur at **a stop sign**?_____**a traffic light**?_____**an intersection**?____
Which area of your car was damaged? **Front Back Left Side Right Side**

What damage was done to your car?
Inside:_____
Outside:_____
Other:_____

Was the other vehicle moving during the collision?____ Approximate speed?_____ mph
If the other vehicle was moving at the time of the collision, was it:
**Slowing Down Accelerating Traveling at a steady speed**

Was the damage to the other car? **Yes No**
Inside:_____
Outside:_____

What type of vehicle were you driving? Make:_____ Model:_____ Year:_____
What condition was your car in prior to the accident?_____
Do you have pictures of the involved automobile? **Yes No**

What is the estimated cost damage to the vehicle you were in? $_____

Which of the following parts of your vehicle were damaged during the accident?
**Windshield** **Right/Left Side Window** **Steering Wheel**
**Other**_____

What other type of vehicle was involved in the accident? **Car** **Truck** **Motorcycle**
Size and type:_____

Was a police report filed? **Yes** **No** By Police of: **City** **County** **State**
Who was ticketed?_____
For what?_____

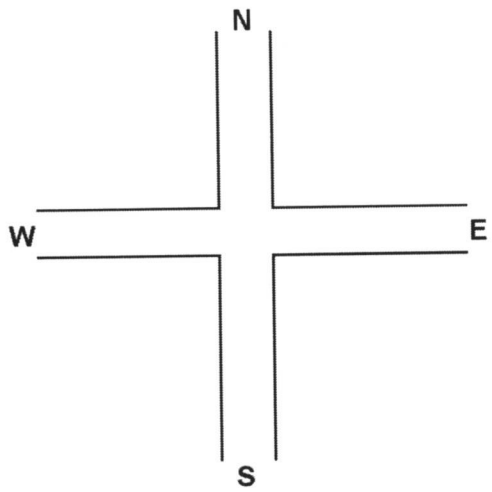
Did your vehicle strike anything else? **Yes** **No**
If Yes, what? **Another Car** **a Sign** **a Tree** **a Bridge** **Other** _____

Did you lose consciousness (black out) on impact? **Yes** **No** How long?_____
Did you experience a flash of light or explosion in your head? **Yes** **No**
Do you remember the impact? **Yes** **No**
Were you aware of the approaching collision prior to impact? **Yes** **No**

Did your vehicle go off the road? **Yes** **No**
If so: **Into an Embankment** **a Ditch** How Deep?_____
Does it bother you to ride in a car now? **Yes** **No** If so, as a: **Driver** **Passenger**

Have you had any time loss from work? **Yes** **No**
Have you had any outside help? **Yes** **No**

**Please Draw the Accident:**




Patient Signature_____Date_____

**Askeland Chiropractic & Acupuncture P.C.**
Dr. Erik J. Askeland D.C

## ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION ("AGREEMENT")

I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals and/or other legal entities ("payers"), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past or future ("condition"), to pay directly to, and exclusively in the name of **Askeland Chiropractic & Acupuncture P.C.** ("office"), such sums as may be owing to **Askeland Chiropractic & Acupuncture P.C.** for charges incurred by me at the office ("charges"). I further grant a contractual lien to **Askeland Chiropractic & Acupuncture P.C.** with respect to my charges, applicable to all payers; however, I understand that nothing in this agreement shall be construed as an election **by Askeland Chiropractic & Acupuncture P.C.** to claim protection under any statutory lien law. For the purposes of the agreement, "benefits" shall include, but shall not be limited to , disability benefits, worker's compensation benefits, medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorist coverage, third party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purposes stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay **Askeland Chiropractic & Acupuncture P.C.**, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to **Askeland Chiropractic & Acupuncture P.C.** to the extent of my charges, as well as any and all causes of action that I might have against such payer, to prosecute such causes of action either in my name or in the office's name, and to settle or otherwise resolve such causes of action as the office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection of this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without expressed written consent of this office. I further direct each attorney to provide immediate notice to the office regarding any funds received by the attorney relating to my accident, to promptly pay such office, and to provide a full accounting of such funds to the office upon its request.

I hereby direct all payers to release to **Askeland Chiropractic & Acupuncture P.C.** any information regarding any coverage or benefits which I may have including, but not limited to, the amount paid thus far, and the amount of any outstanding claims.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this agreement. I hereby direct this office to file a copy of this agreement, together with any applicable charges, with any and/or all payers, regardless of whether a claim has been established with said payees. I hereby authorize **Askeland Chiropractic & Acupuncture P.C.** to endorse/sign my name on any and all checks listing me as a payee, which are presented to this office for payment of any account relating to me, my spouse, or any of my dependents. I further authorize **Askeland Chiropractic & Acupuncture P.C.** to apply any credit balance on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due to **Askeland Chiropractic & Acupuncture P.C.** for their services. This agreement does not constitute any consideration for this office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse **Askeland Chiropractic & Acupuncture P.C.** for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This agreement shall not be modified or revoked without the mutual written consent of **Askeland Chiropractic & Acupuncture P.C.** and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this agreement.

I agree that each and every provision of this agreement is reasonably necessary for the protection of the rights and interests of **Askeland Chiropractic & Acupuncture P.C.** and myself. However, should any provision of this agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be finding on any party hereto, all other portions and provisions of this agreement shall, nevertheless, remain in full force and effect.

Patient Name: (please print) _____

Patient Signature: _____

Date: _____

Name of Parent or Legal Guardian: (please print) _____

Parent/Guardian Signature: _____

Date: _____

# Askeland Chiropractic & Acupuncture P.C.

## Election Not to File Health Insurance Claims
## **(Personal Injury/Accident)**

The chiropractor(s) at this clinic are participating ("in-network") providers for your health benefit plan. As participating providers, we are obligated to file claims for reimbursement with your plan for all covered services provided to you UNLESS you instruct us in writing not to file.

You have indicated that for services related to this personal injury, rather than using your own health insurance, you wish to consider seeking payment from other third-party payors such as the at-fault driver's liability insurance. To help you make an informed decision, please carefully review the following information.

## If you elect NOT to file claims on your health insurance:

1. The clinic will rely on your decision and extend credit to you for the cost of care based on the assumption that your bill will be paid by sources other than your health insurance. **You will be required to assign to the clinic the right to receive monies paid by liability insurers, medical payments insurers or other third-party payors to the extent necessary to satisfy your bill.**

2. You will not be required to pay co-payments/co-insurance and/or deductibles that would normally be required by your health benefit plan.

3. The cost of your treatment will be billed at the clinic's usual rates rather than the discounted rates that routinely apply to services covered by your health benefit plan.

4. If the combined payments received from other sources do not fully satisfy your bill, you may be personally liable for any unpaid balance.

5. None of the charges for your treatment will be applied towards satisfying the annual deductible (if applicable) associated with your health benefit plan.

## If you elect TO file claims on your health insurance:

1. Your health insurance should pay the cost of *covered* services associated with this accident/injury EXCEPT FOR co-payments, co-insurance and/or deductibles, which you will be expected to pay directly to the clinic at the time services are rendered.

2. You will be responsible for paying to the clinic the cost of any *non-covered* services you elect to receive, and your payment will be due at the time services are rendered.

3. If your health benefit plan initially pays the clinic for your treatment and later determines that it is not legally responsible for payment, the plan administrator may require the clinic to refund to the plan all or part of the payments received. If that happens, you will become responsible for reimbursing the clinic the amount it was required to refund.

4. Your health benefit plan requires the clinic to submit claims in a timely fashion and while timely filing requirements vary, most plans require claims to be filed within 3-6 months from date of service. If your action or inaction causes a claim to be submitted late, the claim could be denied, and you would be responsible for paying this clinic for those services which were denied.

## Election not to file health insurance claims:

1. By my signature below, I attest that I have read and understand the above information regarding the options available to me and have been given an opportunity to ask questions and to have those questions answered.
2. I hereby instruct the clinic not to file claims on my health insurance for services associated with this accident/injury, and I authorize the clinic to seek payment from, and send my treatment records to, other third-party payors who are potential sources of payment.
3. I understand that the clinic is relying on my decision not to file health insurance claims, and that with regards to claims related to this accident/injury, this decision is irrevocable.
4. I understand that no subsequent action on my part shall impair the clinic's right to bill and receive payments from third-party payors; subject only to any contractual obligation the clinic may have to my health benefit plan.

_____
**Printed** Name of Patient

_____
Signature of Patient
(or parent/legal guardian, as applicable)

_____
Date:

_____
**Printed** Clinic Representative

_____
Signature of Clinic Representative

_____
Date:

**A complete copy of this executed agreement must be maintained in the patient's health care record, and a copy must be provided to the patient.**

# Med Pay Benefits

A lot of people have benefits included in their automobile policies, such as Med Pay, and don't even realize it. If you have Med Pay, our office highly recommends that you use your coverage, regardless of who is at fault in the automobile accident.

**Here are six (6) reasons why we recommend that we file your Med Pay:**

1) **Increase Your Settlement** – You are more likely to obtain a much higher settlement with Med Pay coverage.

2) **Reduces out-of-pocket expenses** – Even if you are at fault, Med Pay Benefits cover reasonable and necessary medical expenses up to you limit coverage.

3) **Med Pay is similar to Health Insurance** – Using Med Pay does not cause your rates to increase.

4) **Filing your Med Pay doesn't relieve the other party from having to pay in full for your loss** – On the contrary, by filing your Med Pay, when you collect from the other driver's Liability insurance, a greater amount of the settlement will go directly to you because your bill at our office may be paid in full.

5) **Med Pay provides protection** – If the other driver's Liability refuses to make payment to you for whatever reason, filing your Med Pay will help to insure that you are not stuck with all the medical bills.

6) **Med Pay is a benefit** – Filling your Med Pay is common sense since it is a benefit option you are paying.

The important thing to remember is that you are not guaranteed of receiving full payment from the other driver's Liability insurance company. Filing your Med Pay will help to insure that you are not left to pay the medical bills. If we receive overpayment on your account, we will be happy to refund you the difference.