Advanced Spine & Health Center of Cache Valley

# AUTO ACCIDENT FORM

Patient Name: ______________________________________________________ Date: __________________

What are your current symptoms? ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness

Date of Accident ______/_______/_______ Time of accident: _________________ ☐ am ☐ pm

Patient was Located: ☐ Driver ☐ Passenger – middle front ☐ Passenger – right front
☐ Passenger - Left rear ☐ Passenger – middle rear ☐ Passenger – Right rear

| | Compact | Mid-sized | Full size | SUV | Pick-up | Motorcycle | Bicycle |
|---|---|---|---|---|---|---|---|
| **Patient Vehicle Type** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2nd Vehicle Type | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3rd Vehicle Type | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Conditions: ☐ Clear ☐ Dark ☐ Dry ☐ Foggy ☐ Icy ☐ Wet ☐ Other ________________

Road Type: ☐ Asphalt ☐ Concrete ☐ Dirt ☐ Gravel

Were you: ☐ Aware that the accident was going to happen? **OR** ☐ Surprised by the impact?

| | YES | NO | | |
|---|---|---|---|---|
| Were you wearing a seatbelt? | ☐ | ☐ | Lap Belt only ☐ | Lap Belt & Shoulder Harness ☐ |
| Did your airbag deploy? | ☐ | ☐ | Front ☐ Side ☐ | Driver ☐ Passenger ☐ |
| Does your car have a headrest? | ☐ | ☐ | If yes, what position was it in? | ☐ UP ☐ MIDDLE ☐ DOWN |

| **Patients Head position:** | | |
|---|---|---|
| ☐ Left Up | ☐ Looking Up | ☐ Right Up |
| ☐ Left Level | ☐ Straight Ahead | ☐ Right Level |
| ☐ Left Down | ☐ Looking down | ☐ Right Down |

| **Accident Details** | **YES** | **NO** | | **YES** | **NO** | | **YES** | **NO** |
|---|---|---|---|---|---|---|---|---|
| Was your car breaking? | ☐ | ☐ | Was the 2nd Vehicle Braking | ☐ | ☐ | Was 3rd vehicle braking? | ☐ | ☐ |
| Was your car moving? | ☐ | ☐ | Was the 2nd vehicle Moving? | ☐ | ☐ | Was 3rd Vehicle Moving? | ☐ | ☐ |
| IF YES, How fast? ________mph | | | IF YES, How fast? _________mph | | | IF YES, How fast? ________mph | | |

Name of the location/Street on which you were traveling? ________________________________________

In which Direction were you headed? ☐ North ☐ East ☐ South ☐ West

In your own words, please describe the accident:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

| **Collision Details** | **Hit by other Vehicle** | **Hit other vehicle** | **Hit by object** | **Hit object** |
|---|---|---|---|---|
| First impact: | ☐ | ☐ | ☐ | ☐ |
| Second Impact: | ☐ | ☐ | ☐ | ☐ |

| **Impacts on vehicle** | **FRONT** | **FRONT-LEFT** | **FRONT-RIGHT** | **LEFT** | **LEFT-REAR** | **RIGHT** | **RIGHT-REAR** | **REAR** | **TOP** |
|---|---|---|---|---|---|---|---|---|---|
| 1st impact Location | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2nd impact location | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Vehicle Damage:**

| | Totaled | Significant | Light Damage | No Damage |
|---|---|---|---|---|
| Patient Vehicle: | ☐ | ☐ | ☐ | ☐ |
| Second Vehicle: | ☐ | ☐ | ☐ | ☐ |
| Third Vehicle: | ☐ | ☐ | ☐ | ☐ |

1652 South Highway 165, Providence, UT 84332 **Phone** (435) 752-5522 **Fax** (435) 752-3075 **Email** ASHC.chiropractic@gmail.com

**Printed Patient Name:** ______________________________ Date: ____________

**Collision Results:**

| | | | | | |
|---|---|---|---|---|---|
| **Body was thrown:** | ☐ **Forward** | ☐ **Backward** | ☐ **Left** | ☐ **Right** | ☐ **Can't remember** |
| **Head Hit:** | ☐ Airbag | ☐ Windshield | ☐ Rearview Mirror | ☐ Steering wheel | ☐ Dashboard |
| | ☐ Back of front seat | ☐ Side window/door | ☐ Another person's body | ☐ Headrest | |
| **Chest Hit:** | ☐ Airbag | ☐ Steering Wheel | ☐ Dashboard | ☐ Back of front seat | |
| | ☐ Side window/Door | ☐ Another person's body | | | |
| **Shoulders Hit:** | ☐ Shoulder Harness | ☐ Side window/Door | ☐ Back of front seat | ☐ Another person's Body | |

| | Steering Wheel | Dashboard | Back of front seat | Door panel | Center console | Another person's body |
|---|---|---|---|---|---|---|
| Knees Hit: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hips Hit: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Care received after the accident:**

| | **YES** | **NO** | **Immediately** | **Later same day** | **Next day** | **Date** |
|---|---|---|---|---|---|---|
| Were you seen in the ER? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Were you Hospitalized? | ☐ | ☐ | ☐ | ☐ | ☐ | |

Have you seen another healthcare provider for this accident?
Name(s) of Health care provider(s) ____________________
Name of Hospital/ Facility ____________________

**How were you transported to the hospital or health care provider?**
☐ **Ambulance** ☐ **Life flight** ☐ **Private transportation** ☐ **Other**

**What did the hospital recommend?** ☐ **No instructions** ☐ **See chiropractor** ☐ **See Physical Therapist**
☐ **See own doctor** ☐ **See Orthopedist** ☐ **See neurologist** ☐ **Prescribed medication** ☐ **Other**

Did you have XRAYS taken? YES ☐ NO ☐ IF yes, what areas? ____________________
Were you given any medications? YES ☐ NO ☐ IF yes, what? ____________________
Did the accident render you unconscious? ☐ YES ☐ NO ☐ UNSURE IF yes, for how long? ____________

**INSURANCE INFORMATION:**

**Have you submitted a Personal Injury Report to the Insurance Company(s)?** YES ☐ NO ☐

***YOUR Auto Insurance:***

| | |
|---|---|
| Insurance company: | |
| Insurance company contact: | Phone: |
| Insured party: | |
| Claim # | Policy # |
| Vehicle Driver: | |

***OTHER PARTY's Auto Insurance:***

| | |
|---|---|
| Insurance company: | |
| Insurance company contact: | Phone: |
| Insured party: | |
| Claim # | Policy # |
| Vehicle Driver: | |

***Have you retained an attorney?*** ☐ YES ☐ NO IF yes, please notify front office staff

| | |
|---|---|
| Name: | Firm: |
| Phone: | |

***Additional Information***

Number of people with you in the car? ____________ Was this accident reported to the police? ____________
Who was found at fault? ☐ Patient ☐ Other Driver Other (please Explain) ____________
Were traffic Citations issued? ____________ IF yes, to whom? ____________

Patient or Guardian Signature DATE

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Advanced Spine
& Health Center
of Cache Valley

Dr. Thomas Fullmer
Doctor of Chiropractic

# 3rd Party Insurance Acknowledgement and Understanding

Insurance Co: ______________________________ Phone: ________________________________

Address: ___________________________________ Claim#: ______________________________

I hereby acknowledge that I am receiving health care services from Advanced Spine and Health Center of Cache Valley. I have been advised that the doctor providing the services to me is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance reimbursement or out of the settlement of a liability claim or lawsuit.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid to this chiropractic office will be credited to my account upon receipt.

I understand that if it is determined that one or more of the following conditions apply to my case, I am liable to pay for all services rendered to me. *Condition 1:* There is no insurance company obligation to pay for these services, or if the insurance company involved refuses to acknowledge an assignment to the doctor or make other provisions for the protection of the doctor's charges. *Condition 2:* If a liability claim exists, and my attorney (current or future) refuses to agree to protect the interest of the doctor by refusing to sign a lien agreement. *Condition 3:* If I do not engage the services of an attorney.

I agree to pay for all services rendered to me on a current basis and any remaining balance owing on my account will be paid in full as soon as my liability claim is settled or within three months of the date of my last treatment, whichever occurs first. I also understand that if I suspend my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

## Consent of professional services and release of information

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinics charge, including, and not limited to , hospital or medical service companies, insurance companies, workers compensation carriers, welfare funds, or the patients employer.

______________________________ ______________________________
Patient's Printed Name Patient's Date of Injury

______________________________ ______________________________
Patient or Guardian Signature Date

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**IRREVOLCABLE ASSIGNMENT, DIRCTION AND AUTHORITY TO PAY MEDICAL EXPENSES**

Patient Section:

I hereby irrevocably assign, transfer and set over to Advanced Spine and Health Center such sums as may be due and owing for medical rendered, including interest, and to be rendered hereafter to me, or to the person(s) of ______________________________, by reason of the accident on __________________, 20 _____. I hereby irrevocably authorize and direct any person or company having or receiving money due me on such a claim, including my attorney, to pay Advanced Spine and Health Center the unpaid balance of their bill for all professional services rendered to me or to the above-named person(s) before distributing any money to me. This is a direct and irrevocable assignment of rights and benefits under this claim.

I fully understand and expressively acknowledge that I am personally responsible and liable for the payment in full for services rendered by Advanced Spine and Health Center to me or to the above-named persons. Payment to the clinic is not contingent upon obtaining any funds from any third party who may be responsible for my injuries. This agreement is made solely for Advanced Spine and Health Center's protection and in consideration for their awaiting payment. I have been advised that if I do not wish to cooperate in protecting Advanced Spine and Health Center's interest, the clinic will not await payment but may declare the entire balance due and payable by me. In the event this agreement is litigated, shall the clinic prevail, I agree to pay all collection, attorney, and court costs as well as interest charges at the rate of 1.5% per month from the date of beginning treatment.

I acknowledge my agreement to this request by signing below.

Patient or Guardian Signature ______________________ Date ______________________

**Acknowledgement and receipt of assignment**

The undersigned insurance company/attorney does hereby acknowledge receipt of a copy of the above assignment and does agree that prior to the payments of any monies to the above-named patient or patient's guardian, after first subtracting from said funds any attorney fees and costs due and owing as a direct result of representation of the client on the claim which resulted in the injuries being treated at the above named clinic, shall pay Advanced Spine and Health Center all outstanding bills for professional services, if any, directly to Advanced Spine and Health Center.

Attorney Name ______________________ Date ______________________

Law Firm Name ______________________

Print First and Last Name ______________________

***Copy of this document is as an original***

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