Alexander Chiropractic Center

Personal Injury Questionnaire

Name: _____ Date of Accident: _____

1. Were you the ( ) Driver or ( ) Passenger / ( ) Front Seat or ( ) Back Seat

2. Were you hit from ( ) Behind ( ) Front ( ) L Side ( ) R Side

3. Did you strike any part of your body? ( ) Yes ( ) No
   If yes, what part? _____

4. Were you knocked unconscious? ( ) Yes ( ) No If yes explain duration: _____

5. Where were you taken after the accident? _____
   Were X-rays taken? ( ) Yes ( ) No

6. Have you been treated by another doctor since the accident? ( ) Yes ( ) No
   If yes, please list the doctor's name and phone number: _____

7. Please briefly describe the accident: _____
   _____
   _____

8. Please briefly describe how you felt...a) Immediately after the accident: _____
   b) Later that same day: _____
   c) The next day: _____

9. What are your PRESENT complaints and / or physical symptoms: _____
   _____

10. Do you have any previous illness or physical complaints that relate to this case? ( ) Yes ( ) No
    If yes, please explain: _____

11. Did you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No
    If yes, please describe: _____

12. Have you lost time from work as a result of this accident? ( ) Yes ( ) No - If yes, last date worked: _____

13. Since the accident occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same?

14. Have you ever been in a previous auto accident? ( ) Yes ( ) No If yes, when? _____

15. Were you treated for injuries as a result of your previous accident? ( ) Yes ( ) No
    If yes, what were the results of your treatment? _____

16. Do you have any continued complaints from your previous accident? ( ) Yes ( ) No
    If yes, please explain: _____

Please read *before* signing:

I agree to participate in medical and therapy treatments by this provider and accept that no guarantee of results or outcome is expressed. I hereby authorize payment for medical benefits to **Alexander Chiropractic Center** for services rendered.

_____ _____ _____

Patient Signature | Parent / Guardian Signature | Today's Date

Alexander Chiropractic Center

Motor Vehicle Accident Insurance Questionnaire

Name: _____ Accident Date: _____

State accident occurred in: _____

1. Has the accident been reported to the police? Y / N If yes, were they at the accident scene? Y / N If yes, was anyone cited? Y / N
   If yes, whom? ( ) Myself ( ) My Driver ( ) The other driver ( ) Other _____
2. Have you retained an attorney? Y / N If yes, name of your attorney: _____
   Address: _____ Suite #: _____
   City: _____ State: _____ Zip Code: _____
   Phone #: ( ) _____ Fax #: ( ) _____
3. Have you reported the accident to any insurance company? Y / N
   If yes, which one(s)? ( ) My own ( ) My driver's ( ) The owner of the vehicle I was in
   ( ) the other driver's ( ) The owner of the other driver's vehicle
4. Were you in your own vehicle at the time of the accident? Y / N If yes, skip to Box 2.

BOX 1 – Information about the vehicle you were in, if it was NOT your own.

Insured's Name: _____ Relationship to yourself: ( ) Self ( ) Spouse ( ) Child ( ) Other

Insured's address: _____

Insured's Phone#: ( ) _____ Insurance Co Phone #: ( ) _____

Ins Co for the vehicle you were in: _____ Policy #: _____

Medical Adjuster's Name: _____ Claim #: _____

Medical Adjuster's Phone #: ( ) _____ Ext.: _____

Insurance Billing Address: _____ Attn: _____

BOX 2 – Your vehicle information: (Regardless if you were in someone else's vehicle at the time)

Insured's Name: _____ Relationship to yourself: ( ) Self ( ) Spouse ( ) Child ( ) Other

Insured's address: _____

Insured's Phone#: ( ) _____ Insurance Co Phone #: ( ) _____

Ins Co for the vehicle you were in: _____ Policy #: _____

Medical Adjuster's Name: _____ Claim #: _____

Medical Adjuster's Phone #: ( ) _____ Ext.: _____

Insurance Billing Address: _____ Attn: _____

BOX 3 – Information pertaining to the person that hit you:

Insured's Name: _____ Relationship to yourself: ( ) Self ( ) Spouse ( ) Child ( ) Other

Insured's address: _____

Insured's Phone#: ( ) _____ Insurance Co Phone #: ( ) _____

Ins Co for the vehicle you were in: _____ Policy #: _____

Medical Adjuster's Name: _____ Claim #: _____

Medical Adjuster's Phone #: ( ) _____ Ext.: _____

Insurance Billing Address: _____ Attn: _____

Have you received the Personal Injury Protection forms from your insurance company? Y / N
If yes, have you returned them to the insurance company? Y / N Do you have a copy? Y / N

The information given in this questionnaire is true to the best of my knowledge.

_____ Patient / Guardian Signature

_____ Witness Signature

_____ Today's Date

Alexander Chiropractic Center

14350 Solomons Island Rd Suite 103A
Solomons, MD 20688-1269
Phone: 410-394-1000

22930 Three Notch Rd
California, MD 20619
Phone: 301-737-4007

ASSIGNMENT AND AUTHORIZATION

You are hereby authorized to disclose and/or furnish my attorney(s) with any and all medical information, bills, and/or records in your possession which they request in reference to any illnesses and injuries which I have suffered.

I further, irrevocably assign to you, and authorize and direct said attorneys to pay from the proceeds of any recovery in my case all reasonable fees for services provided by you, including fees for preparation and testimony, as a result of the injury or condition heretofore mentioned. I understand that this in no way relieves me of my personal primary obligation to pay for such services and that the signing of this form does not prohibit customary billing by you. All bills shall be paid promptly in the usual manner. This specifically includes but is not limited to any and all Pip, Med-Pay, or Med-Expense payments. I hereby further give a lien on my case to said doctors against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith

It is further understood that there is a Statute Of Limitations applicable to any civil claim you may bring. In view of this, I hereby agree that the Statute Of Limitations with respect to any claim for services mentioned above will not begin to run until I send you a denial, in writing, of any outstanding balance. Said written denial *must* be mailed certified mail, return receipt requested, and said return receipt will be required to show proof of the notice of this denial.

Signature: _____ Date: _____

Witness: _____

THE UNDERSIGNED ATTORNEY FOR THE PATIENT REFERRED TO ABOVE HEREBY AGREES TO COMPLY FULLY WITH THE FOREGOING "AUTHORIZATION AND ASSIGNMENT" AND AGREES TO ADVISE THE NAMED ASSIGNEE IN WRITING THE STATUS OF THE CLAIM OF THE ATIENT WITHIN TEN (10) DAYS OF THE REQUEST, AND AGREES TO NOTIFY THE ASSIGNEE IF THE ATTORNEY CEASES TO REPRESENT THIS PATIENT AND/OR IF THE CLAIM IS DROPPED OR DENIED.

_____

Attorney

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ASSIGNMENT OF BENEFITS AND RIGHT TO SUE FOR PIP

To Whom It May Concern:

I hereby authorize and direct any insurance company with whom I may make a claim for PIP or Med-Expense benefits, and/or my attorney, to pay directly **Alexander Chiropractic Center**, (hereinafter referred to as "this health provider"), any money that is owed to this health provider for services provided to me.

In the event that any insurance company that is obligated to reimburse me for charges I incur with this health provider refuses to make such payments after demand is made by either me or this health provider, I hereby assign and transfer to this health provider any and all causes of action that I have against said insurance company, including but not limited to the right to bring a lawsuit, for the failure to pay the available PIP and/or Med-Expense benefits up to the amount of this health provider's full bill.

I authorize this health provider to bring any such cause of action either in my name or in this health provider's name. I further authorize this health provider to compromise, settle or otherwise resolve any such claim arising out of the insurance company's failure to pay to this health provider the full limit of available PIP or Med-Expense benefits up to the amount to its full bill.

I understand that I remain personally responsible for the total amounts due to this health provider for its services. I understand that payment is due at the time services are rendered, and that this health provider is providing a *courtesy* to me by trying to have the bill paid through alternative sources. I agree that this document does not constitute any consideration for this health provider to await payment, and that payment may be demanded from me immediately upon the rendering of services.

I authorize this health provider to release any information pertinent to my case to any insurance company or attorney to facilitate the collection of my bill. I agree that this health provider be given Power of Attorney to endorse or sign my name on any and all checks for payment of my doctor bill.

Patient: _____

Date: _____

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Third Party Disclaimer

I understand that according to the coordination of benefits portion of my health insurance, there will be no "provider discount" that applies when my third party liability case is processed, through my health insurance. I understand that I am ultimately responsible for all services rendered by **Alexander Chiropractic Center**, with no regard to the practice's participation with my health insurance, in this matter.

_____	_____	_____
Patient Signature	Witness Signature	Today's Date