PERSONAL INJURY / AUTOMOBILE ACCIDENT DETAIL FORM

Patient Name: _____ Today's Date: _____ / _____ / _____

Date of Accident: ____ / ____ / ____ State: _____ Time: ___:___ am / pm

Were You: ( ) Driver ( ) Passenger ( ) Pedestrian

Were you struck from: ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked

Were there other passengers/drivers in your vehicle: ( ) Yes ( ) No

Did your car strike the others involved: ( ) Yes ( ) No ( ) Undetermined

Did the other car strike yours: ( ) Yes ( ) No ( ) Undetermined

As a result of the Accident, were traffic citations issued to you? ( ) Yes ( ) No

Explanation of Accident:

_____

_____

_____

_____

_____

_____

Check symptoms you have noticed since the Accident:

__ Headache __Sleeping Problems __Light Sensitivity __Diarrhea __Neck Pain __Head too heavy

__ Memory Loss __Cold Feet __Stiff Neck __Pins & Needles __Ears Ringing __Cold Hands

__ Dizziness __Face Flushed __Upset Stomach __Back Pain __Numb Fingers __Buzzing Ears

__ Constipations __Nervousness __Numb Toes __Loss of Balance __Cold Sweats __Tension

__ Short Breath __Fainting __Loss of Smell __Chest Pain __Depression __Fatigue

__ Loss of Taste __Other

Did you require post-accident hospitalization? ( ) Yes ( ) No

Have you lost any days of work? ( ) Yes ( ) No If Yes, ____ / ____ / ____ through ____ / ____ / ____

Patient / Guardian Signature: _____ Today's Date: _____ / _____ / _____

PERSONAL INJURY/AUTOMOBILE ACCIDENT FINANCIAL POLICY

Our Personal Injury/Automobile Insurance Assignment Program is designed to render you immediate care and keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your insurance carrier on your behalf and wait up to six months for payment. Please remember, however, that you are ultimately responsible for payment of all services rendered to you regardless of insurance coverage or settlement status. Termination of care prior to your doctor's release will result in all balances being due immediately. Please notify us if you are using an attorney. Listed below are payment options for your personal injury claim.

MEDICAL PAYMENTS

"Medical Payments" or "Med-Pay" is part of your own auto insurance policy which will immediately cover the costs of your medical expenses given by a licensed health care provider and those of any passengers in your car, up to a certain limit, regardless of fault. Senate Bill 08-011, effective January 01, 2009, made Med-Pay benefits mandatory on all auto insurance policies unless specifically rejected in writing or declined during the application process. If payment is made by this method, and you are not at fault, your insurance premiums will not be increased, and you will not have to repay any benefits. This will allow you to get the treatment you need for your injuries without the hassle of dealing with the other party's insurance company. Med-Pay is primary for services rendered to personal injury patients when available.

HEALTH INSURANCE

Your Group or Individual Health Insurance may cover your medical expenses resulting from injuries sustained in an automobile accident. If coverage is available, your health insurance company may seek reimbursement for payments made from the third party. We will assist you in verifying your coverage. You will be responsible for any co-payments or deductibles that your policy requires. In certain instances, we may be able to wait for payment for copays and deductibles until a settlement is reached with the third party.

THIRD PARTY

Colorado is currently an "at-fault" state regarding payment of claims resulting from an automobile accident or personal injury. This means the responsible party, or his or her insurance, should cover the cost of medically necessary treatment given by a licensed health care provider. Such claims are considered for payment when all treatment is complete and a settlement is reached with the third party. If available, Med-Pay and your personal health insurance will be billed before attempting collection from the at-fault party. We will accept a medical provider's lien and a credit card guarantee from you and wait up to six months after the conclusion of your care for payment if no other payment options exist.

SELF PAY

You also have the option of paying at the time of service for your care and seeking reimbursement from the responsible party/insurance carrier yourself. If you prefer to do this, we will provide itemized statements along with detailed records and reports upon request.

All financial and claims documents must be completed prior to the second visit or no treatment can be given.

I have read and understand the personal injury/automobile accident financial policy of PLE Chiropractic. I understand that I am ultimately responsible for any services rendered to me by PLE Chiropractic. Payment for services is not contingent upon my insurance coverage or settlement with a third party. I understand that if I terminate care outside my doctor's recommendations, any balances will be due immediately.

Patient / Guardian Signature: _____ Today's Date: _____ / _____ / _____

ASSIGNMENT OF BENEFITS

I hereby assign all healthcare benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including automobile insurance, private health insurance, third party insurance, and any other health/ medical plan, to issue payment check(s) directly to PLE CHIROPRACTIC for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am ultimately responsible for any amount not covered by my insurance or any third party. I understand that this assignment given to PLE CHIROPRACTIC herein is irrevocable.

Patient / Guardian Signature: _____ Today's Date: _____ / _____ / _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize PLE CHIROPRACTIC to: (1) release any information necessary to insurance carriers regarding my injuries and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

Patient / Guardian Signature: _____ Today's Date: _____ / _____ / _____

PERSONAL INJURY / AUTOMOBILE ACCIDENT CLAIM INFORMATION FORM

Patient Name: _____ Today's Date: _____ / _____ / _____

YOUR AUTO INSURANCE POLICY

Name of Company:_____

Telephone #:_____

Name on Policy:_____

Policy #:_____

Claim #:_____

Claims Representative Name and Telephone #:_____

Do you have Medical Payments Benefits on your policy? ( ) Yes, Amount:$_____ ( ) No ( ) I don't know

THIRD PARTY INSURANCE POLICY

Third Party's Name:_____

Name of Company:_____

Telephone #:_____

Name on Policy:_____

Policy #:_____

Claim #:_____

Claims Representative Name and Telephone #:_____

Patient / Guardian Signature: _____ Today's Date: _____ / _____ / _____

ASSIGNMENT, LIEN, RELEASE & POWER OF ATTORNEY

THIS AGREEMENT, entered into this date and between _____ called "PATIENT" and PLE CHIROPRACTIC, WHEREAS Patient desires to receive chiropractic services from PLE CHIROPRACTIC, and desires to assign certain rights and benefits to PLE CHIROPRACTIC as consideration for PLE CHIROPRACTIC awaiting payment of such benefits. Accordingly, it is hereby agreed:

A. Patient hereby authorizes PLE CHIROPRACTIC to furnish a full report and records regarding case history, examination, diagnosis, treatment and prognosis, x-rays, laboratory reports and the results of all tests of any type or character of patients such persons as PLE CHIROPRACTIC deems appropriate.
B. Patient's assigns to PLE CHIROPRACTIC any and all benefits payable by Patient's insurance or health care plan(s) as a result of charges incurred by Patients for services rendered by PLE CHIROPRACTIC. Patient also assigns to PLE CHIROPRACTIC any and all contractual rights Patient has against insurance company, health care benefit plan, or any other party possibly liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by PLE CHIROPRACTIC.
C. Patient fully understands that Patient is directly and fully responsible to PLE CHIROPRACTIC for all bills submitted for services rendered and that this agreement is made solely for additional protection and consideration for awaiting payment. Patient further understands that such payment is not contingent on any settlement, claim, judgment, or verdict which Patient may eventually recover. In the event of non-payment by any insurance company, health care benefit plan, or any other party possible liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by PLE CHIROPRACTIC, Patient agrees to be responsible for any such outstanding balance, including interest at a rate of 9% of all services rendered.
D. Patient fully understands that the lien and assignment given to PLE CHIROPRACTIC herein is irrevocable.
E. By executing this agreement, Patient hereby instructs and directs any attorney-representing Patient to honor the above lien and assignments and make payment under the lien and assignment directly to PLE CHIROPRACTIC. Patient directs that attorney be bound by this lien and treat it, irrevocably, as an assignment due to PLE CHIROPRACTIC. PLE CHIROPRACTIC is relying upon this lien, assignment and directive to any attorney, and as a result of such reliance, PLE CHIROPRACTIC is providing care and treatment for which this lien, assignment and directive provide security for payment. Moreover, Patient agrees that PLE CHIROPRACTIC is to be viewed as a third party beneficiary of this direction to Patient's attorney and it is Patient's intent to impose upon Patient's attorney an obligation to comply with the terms of this directive.
F. Patient hereby directs all insurers and other persons possibly responsible for Patient's healthcare costs to make all payments for healthcare services rendered by PLE CHIROPRACTIC directly to PLE CHIROPRACTIC.
G. Patient agrees that in the event Patient receives any check, draft, or other payment subject to this agreement, Patient agrees to act as fiduciary agent for PLE CHIROPRACTIC and will immediately deliver said check, draft, or payment to PLE CHIROPRACTIC to be applied to Patient's debt for services rendered.
H. Patient hereby appoints PLE CHIROPRACTIC as Patient's true and lawful attorney, irrevocable, and with full power of substitution, for Patient and in Patient's name, to ask, demand, sue for, collect, endorse, sign and receive proceeds from insurance, other health benefits, and third party claims relating to services rendered to Patient by PLE CHIROPRACTICPLE CHIROPRACTIC is not obligated or compelled to exercise such powers but may do so in PLE CHIROPRACTIC's sole discretion. Patient agrees to fully cooperate with PLE CHIROPRACTIC in collecting said amounts. PLE CHIROPRACTIC agrees to submit a copy of this agreement with the initial claim form(s) which PLE CHIROPRACTIC submits to third party payer(s) as notice to the third party payer(s) of the assignment and other agreements contained herein. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in Patient's file and may be picked up by the Patient, upon reasonable request and during normal business hours, or upon written request by Patient, be mailed to designated address.
I. Patient hereby authorized PLE CHIROPRACTIC to receive a complete copy of Patient's insurance policy, including any endorsements, conditions, limitations or exclusions.
J. A copy of these documents shall be as binding as the document bearing the original signatures.

Patient / Guardian Signature: _____ Date: _____ / _____ / _____

PLE Chiropractic:_____Date: _____ / _____ / _____

Valley State Bank V. Dean, 97 Colo. 151, 47 P. 2nd 924 (1935)
Fort Lupton State Bank v. Murata, 626 P.2d 757 (Colo. App. 1981)
Barcucas v. Bohemia Import Co., Inc., 518 P.2d 850 (Colo. App. 1974)
Thomas v. Oken, 699 P2d (Colo. App. 1984)