AUTO ACCIDENT

Name _____ Sex _____ Age _____

Address _____

City _____ State _____ Zip _____

Date and time of accident? _____

Where were you taken after the accident? _____

Where did you feel pain? _____

What are your symptoms? _____

_____

Name of any other Doctor consulted since your accident: _____

Treatment received: _____

How often did you receive care from the other Doctor? _____

Have you previously been injured in a similar manner? _____

Have you retained an attorney? ☐ Yes ☐ No Name _____

Address _____

City _____ State _____ Zip _____

Name of insurance company? _____

Address _____

City _____ State _____ Zip _____

PLEASE EXPLAIN FULLY HOW YOUR ACCIDENT HAPPENED:

(Use reverse if necessary)

Were you wearing a seat belt? ☐ Yes ☐ No

Where were you seated in the car? _____

Please describe the accident: _____

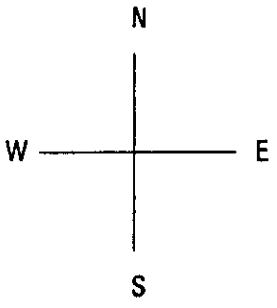
_____

_____

_____

_____

_____



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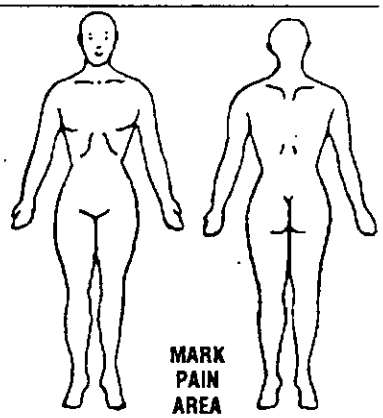

+++ Burning
000 Stabbing
--- Sharp
||| Constant

Name:_____ Date:_____

•Please write any additional information about the accident that was not covered:

_____

_____

_____

_____

_____

_____

_____

_____

FINANCIAL RESPONSIBILITY/AUTHORIZATION OF TREATMENT

Payment is expected at time of visit unless other arrangements are made in advance.
Name of person responsible for this payment: _____
Do you have health insurance? YES NO
Health Insurance Company's name: _____
You must provide this office with your health insurance card.
If any automobile insurance company will be charged – you must provide the following information:
Auto insurance Company name: _____Phone#:_____
Adjuster in charge of case: _____Claim #: _____

The insurance company must agree to honor direct payment to this office upon settlement of your case.
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I also understand that I am responsible for payment for services rendered if my insurance company deems the provided services not medically necessary despite being clinically appropriate. Any amount authorized to be paid directly to the Island Chiropractic Centre will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that **I AM PERSONALLY RESPONSIBLE FOR PAYMENT.** I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.I also understand that if I am accepted as a patient by the physicians of Island Chiropractic Centre, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks regarding chiropractic treatment will be explained to me upon my request. The doctor will not be responsible for any pre-existing medical conditions nor for any medical diagnosis. If health insurance is filed and paid, the full remaining amount of the bill is due regardless of the excepted amount paid by the insurance company.

Patient's Signature: _____Date: _____

Guardian or Spouse's Signature Authorizing Care of a Minor:
_____Date: _____

ASSIGNMENT OF PROCEEDS, LIEN, AND AUTHORIZATION

I hereby authorize and 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, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future ("condition") to pay directly and exclusively in the name of **Dr. Anthony Ross (DAR)** such sums as may be owing to **DAR** for charges incurred by me at the Office relating to my condition ("charges"), with such payments to be made exclusively in the name of **Dr. Anthony Ross**. I further grant a lien and power of attorney to **DAR** with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law. For the purposes of this document (herein, "Assignment and Lien") "benefits" shall include, but not limited to, proceeds from any settlement, release agreement, judgment, verdict, or attorney retainer agreement, as well as any proceeds relating to commercial health or group insurance, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability coverage, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein, whether in compensation for medical expenses or any other type of damage recognized by law.

In the event that I retain one or more attorneys to represent me in this matter who are not located in South Carolina, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon insurance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office.

I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers defined above to facilitate collection under this Assignment and Lien. I further authorize and direct all payers to release to **DAR** any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I hereby direct this office to file a copy of this Assignment and Lien, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize **DAR** to endorse/sign my name on any and all checks listing me as a payee which are presented to this Office for payment of an account relating to me, my spouse, or any of my defendants. I further authorize **DAR** to apply my credit balances on charges incurred by me to any other outstanding charges still owed by my spouse, my dependents,, or me regardless if these other charges are related to my condition.

In the event that my charges are filed with two or more primary payers in their amount, and any of these payers either requests or applies a discount to my charges, by contract or otherwise, I hereby waive the discount and authorize **DAR** to collect the discounted amount directly from the other payers. This waiver shall apply regardless of whether payment is in compensation for medical expenses, or for any type of damages recognized by law, provided that such payment is related to, or based upon, the submission or filing of my full charges. This waiver shall not apply where such waivers are expressly prohibited by law.

I understand that I remain personally responsible for the total amounts due **DAR** for their services. This Assignment and Lien does not constitute any consideration for this Office to await payments and it may demand payments form 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 **DAR** for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Assignment and Lien shall not be modified or revoked without the mutual written consent of **DAR** and myself. I hereby revoke any previously signed authorization conflict with the terms of this Assignment and Lien.

Patient Name (please print):_____

Patient Signature:_____ Date: ____/____/____

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

Parent/Guardian' Signature:_____ Date: ____/____/_____

Island Chiropractic Centre

Dr. Anthony C. Ross, PO Box 1149 • John's Island, SC 29457 • (843) 559-9111 • Fax (843) 559-5525

Email: iccji@bellsouth.net Website: charlestonchiropractic.com

I, _____ request direct payment to Dr. Anthony C. Ross for payment of treatment/services rendered due to injuries sustained in the accident of _____.

Please honor my request to forward payment directly to Dr. Anthony Ross out of my settlement for this accident. The Doctor and Insurance Company can be assured that I will not set aside this agreement now or in the future.

This agreement is not revocable by me or my representative.

Signed:_____Date:_____