Optimum Health Chiropractic
Dr. Catherine Hoag

Patient Name_____ **Date**_____

Dear Patient,

We are sorry to hear about your recent personal injury. As a courtesy to our patients with personal injury claims we will file to the appropriate insurance companies including liability, Med Pay, and commercial health insurance.

Please provide the following information on your **next visit**: (all that apply)

□ Name of emergency facility where you were treated: _____

□ X-rays/Medical reports pertaining to your injury: _____

□ Copy of Police Report

□ "Courtesy" Slip or other information completed by the police officer at the scene of the accident

□ Copy of your driver's license

□ Copy of your Registration Card

□ Information regarding the liability insurance (see attached sheet)

□ Information regarding your auto insurance Med Pay coverage (see attached sheet)

□ Copy of your health insurance card (s)

We would like to take care of your claim as quickly and easily as possible. Thank you for your cooperation.

6521 Creedmoor Rd., Suite 102, Raleigh, North Carolina 27613
919-845-7279, Fax 919-870-9499

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To any insurance company with coverage applicable to my claims(s) and to any attorney representing me:

Assignment of Benefits

I irrevocably assign to Optimum Health Chiropractic any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on _____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to Optimum Health Chiropractic, from any disability benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due or may become due to Optimum Health Chiropractic for its services rendered.

I appoint Optimum Health Chiropractic as my attorney in fact to affix my name as an endorsement upon reverse of any check or draft upon which I am named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Optimum Health Chiropractic.

I authorize Optimum Health Chiropractic to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to Optimum Health Chiropractic for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. **I agree that during the course of my treatment, if I do not have Med Pay coverage I am responsible to pay at minimum the Self Pay rate per visit while awaiting payment from any third-party payer. If I do have Med Pay coverage and it becomes exhausted I am responsible to pay the Self Pay rate per visit while awaiting payment for any third-party payer unless my health insurance is in-network with SCC and can be filed.**

Patient Name (printed):_____

Patients Signature: _____ Date _____

Notice of Lien

Pursuant to N.C.G.S. 44-49 and 44-50, Optimum Health Chiropractic hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for settlement of injuries sustained, whether in litigation or otherwise.

Optimum Health Chiropractic hereby requests that if its claim is not paid in full from the forgoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.'s 44-50.1. Optimum Health Chiropractic agrees to be bond by any confidentiality agreements regarding the contents of the accounting.

By:_____

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If "Yes", specify what part of the body struck what: (i.e. head to windshield) _____

- Did your seat bend or break? **Yes / No**
- Immediately following the accident, how did you feel? (Circle all that apply) **Dizzy / Dazed / Weak / Upset / Disoriented / Nervous / Nauseous / Other** : _____

Police and Ambulance:

- Was the accident reports to the police? **Yes / No**
- Were traffic citations issued? **Yes / No** If "YES", to whom? _____
- Did you go to the hospital? **Yes / No** If "YES", when? _____
- If "YES", how did you get there? **Ambulance / Police Car / Private Transportation**
- Were you admitted? **Yes / No** If "YES", how long? _____
- Name of Hospital? _____ Attended by Dr. _____
- What treatment was given? (Circle all that apply) **None / X-rays / Pain Medication / Stitches / Muscle Relaxants / Bandaged / Cervical Collar / Physical Therapy / Instructed Regarding Concussion / Instructed Regarding Sprains & Strains / Instructed to Call an Orthopedist / Instructed to call a Private Physician / Referred to This Office / Other:** _____
- What other doctor have you seen as a result of this injury? _____
- Do you have difficulty in excessive: **Standing / Walking / Riding / Bending / Twisting**
- Do you have difficulty in excessive lifting: **Light / Moderate / Heavy / Repetitive**
- Symptoms other than above: _____

Patient Signature **Date**

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AUTO ACCIDENT MECHANISM OF INJURY FORM

Patient's Name: _____ DOB: _____ Z Code: _____

Date of Collision: _____ Hour of accident: _____ AM/PM

Location of Accident: _____

Please describe how the collision happened: _____

_____

_____

_____

- What was your position in the car? (Circle) **Driver / Front Passenger / Left Rear / Right Rear**
- If "Driver", were your hands on the steering wheel? **Both / Left / Right**
- Did the airbags deploy? **Yes / No**
- Did you strike another vehicle? **Yes / No**
- Angle of Impact: **Front / Back / Left / Right / Other**: _____
- If Second Collision – Angle of 2nd impact: **Front / Back / Left / Right / Other** : _____
- In relation to the back of your head, was your headrest set: **Low / Middle / High**
- Were you surprised by the impact? **Yes / No**

  If "NO", how did you brace? **With Hands / With Feet**
- Where was your head facing at the time of impact? **Straight Ahead / Left / Right / Behind**
- Were you leaning forward at the time of impact? **Yes / No**
- What type and year of vehicle were you in? _____
- What was the approximate speed of your vehicle when the accident occurred? _____mph
- What type and year of vehicle struck yours? _____
- What was the approximate speed of the other vehicle when the accident occurred? _____mph
- Were you wearing a seatbelt? **Yes / No** What type: **Lap Belt / Shoulder Belt / Both**
- Did you feel pain immediately after the accident? **Yes / No**
- Were you rendered unconscious as a result of the accident? **Yes / No**
- Did you strike anything in the vehicle at the time of impact? **Yes / No**

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