VALENTE CHIROPRACTIC

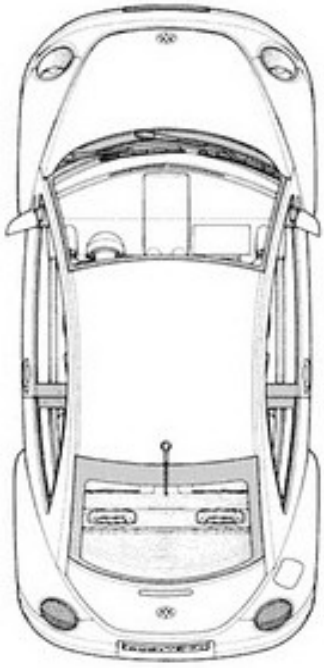
Motor Vehicle Collision Form

Name: _____ **DOB:** _____ **Today's Date:** _____

Report of Accident:

Date of Accident:_____ Time of Accident:_____❑A.M. ❑P.M. City of Accident: _____
Street of Accident that your car was on: _____ Cross Street (intersection): _____
Road conditions at the time of incident: ❑Wet ❑Dry ❑Icy ❑Other _____
Were there any witnesses? ❑Yes ❑No Were you wearing your seat belt? ❑Yes ❑No
Did the police come to the scene of the accident? ❑Yes ❑No Was an accident report filed? ❑Yes ❑No
If a traffic violation was issued, to whom was it issued? _____
Please explain the details of the accident to the best of your knowledge: _____
_____
_____
_____

Indicate where the initial impact struck your vehicle by marking an "X" on the diagram below:



The following questions pertain to you, the patient, and the vehicle you were in:
Number of people in accident vehicle: _____
Were you the: ❑Driver ❑Front Passenger ❑Rear Passenger
Were you ❑aware of the approaching collision ***or*** ❑surprised by impact?
Were you rendered unconscious? ❑Yes ❑No If yes, for how long?_____
Was this vehicle equipped with airbags? ❑Yes ❑No
If yes, did it/they inflate? ❑Yes ❑No
What did your vehicle impact? ❑Another Vehicle ❑Other _____

Vehicle Information & Velocity pertaining to the vehicle you were in:
Vehicle Year: _____ Make:_____ Model: _____
What direction was your vehicle traveling? ❑North ❑South ❑East ❑West
Was your car ❑Moving ***or*** ❑Stopped
If your car was moving:
How fast were you traveling? Approximately _____ MPH
Just before impact, the vehicle you were in was:
❑Slowing down ❑Speeding Up ❑Constant Speed
Did the impact to your vehicle come from the:
❑Front ❑Rear ❑Right Side ❑Left Side ❑Other: _____

The following questions pertain to the other vehicle involved in the accident:
Other Vehicle Year: _____ Make:_____ Model: _____
What direction was the other vehicle traveling? ❑North ❑South ❑East ❑West
Was the other car ❑Moving ***or*** ❑Stopped
If the other car was moving:
How fast was it traveling? Approximately _____ MPH
Just before impact, the other car was:
❑Slowing down ❑Speeding Up ❑Constant Speed

Were there bleeding cuts caused by the accident? ❑Yes ❑No Where: _____
Where there any bruises caused by the accident? ❑Yes ❑No Where:_____
If any part of your body struck anything during the collision please describe what and where: _____
_____
What were the cost of damages to the vehicle you were in? $_____
Which (if any) of the following car parts broke during the accident:
❑Windshield ❑Steering Wheel ❑Front Seat ❑Back Seat ❑Side Window (R/L) ❑Other_____
Was the trunk of your body pointed straight forward at the time of impact? ❑Yes ❑No
If No, which direction was it pointed, and by how much? _____
Was your head pointed straight forward at the time of impact? ❑Yes ❑No
If No, which direction was it turned, and by how much? _____

If you have been involved in previous auto accidents, please list the year of each incident:

_____

Please list any additional information not covered above that we should know about:

_____

_____

_____

Insurance Information:

YOUR INSURANCE INFORMATION:

Do you have PIP (Personal Injury Protection) on your policy: ❑Yes ❑No

Name of Insurance Company:_____
Policy #: _____ Claim #: _____
Insured's Name: _____ DOB: _____
Name of Claim Representative: _____ Telephone #: _____

THE OTHER PARTY'S INSURANCE INFORMATION:

Name of Insurance Company:_____
Policy #: _____ Claim #: _____
Insured's Name: _____ DOB: _____
Name of Claim Representative: _____ Telephone #: _____

Attorney Information:

Name of Attorney/Law Office: _____ Telephone #: _____
Address of Attorney:_____ City: _____ State: _____ Zip:_____

Medical Care:

Have you gone to a Hospital or seen any other Doctor? ❑Yes ❑No
When did you go? ❑Just after accident ❑Next Day Other:_____
Mode of Transportation: ❑Ambulance ❑Privately transported
Name of Hospital and/or Attending Doctor:_____
_____
Was he/she a: ❑D.C. ❑M.D. ❑D.O. ❑D.D.S. ❑P.A.

Were X-Rays taken? ❑Yes ❑No
If yes, what was X-Rayed: _____
_____
Was medication prescribed? ❑Yes ❑No
Describe any treatment you received:
_____

Work:

To evaluate the effect that continuing work will have on your recovery please complete the following:
Have you been able to work since the injury? ❑Yes ❑No

Are your work activities restricted as a result of your injuries sustained? ❑Yes ❑No

How many hours are in your normal work day? _____

What can you do for work with minimum physical effort and for how long? _____❑N/A

Prior to the injury were you capable of working on an equal basis with others your age? ❑Yes ❑No ❑N/A

While in recovery, is there any light duty work you could request? ❑Yes ❑No ❑N/A

Please indicate your daily job duties and any activities in which you are occasionally asked to perform:
❑Standing ❑Sitting
❑Walking ❑Lifting
❑Driving ❑Twisting
❑Crawling ❑Bending
❑Operating equipment ❑Working with arms above head
❑Typing ❑Stooping
❑Other: _____

Patient Signature _____ **Today's Date:**_____

VALENTE
CHIROPRACTIC

Assignment of Benefits and Release of Information

HEALTH COVERAGE INFORMATION

Primary Health Insurance	Secondary Health Insurance (if any)
Insurance Company: _____	**Insurance Company:** _____
Member / ID No.: _____	**Member / ID No.:** _____
Group No.: _____	**Group No.:** _____
Subscriber Name: _____	**Subscriber Name:** _____
Subscriber Birthdate: _____	**Subscriber Birthdate:** _____
Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____	**Patient Relationship to Subscriber:** ☐ Self ☐ Spouse ☐ Child ☐ Other _____

☐ **Veterans:** Some or all my services may be covered under an approved VA CCN / TriWest authorization. I authorize Valente Chiropractic PLLC to submit claims and receive payment directly for VA-authorized services, subject to the applicable authorization and VA/TriWest program rules. **Veteran ICN:** _____

AUTO / WORKERS' COMPENSATION CLAIM INFORMATION

Date of injury: _____ **Attorney (if applicable):** _____

☐ 1st Party Auto	☐ 3rd Party Auto	☐ Workers' Comp / L&I
Your auto insurance	*Other party's auto insurance*	Claim no.: _____
Claim no.: _____	Claim no.: _____	Employer: _____
Auto insurer: _____	Other insurer Co.: _____	Claim manager: _____
Personal Injury Protection:	**If no PIP or after PIP is Exhausted:**	**My Employer is insured with:**
☐ I have PIP/Med Pay on my policy	☐ Bill my Health Ins **-OR-** ☐ Wait for Settlement	☐ WA LNI **-OR-** ☐ Self Insured Worker Comp

ASSIGNMENT, RELEASE, AND FINANCIAL RESPONSIBILITY

- **Certification and assignment.** I certify that I, and/or my dependent, have the coverage or claim listed on this form. I assign directly to Valente Chiropractic PLLC, its treating providers, and/or its assignees all insurance, claim, and other benefits payable for services rendered. I request that payment be made directly to Valente Chiropractic PLLC to the extent allowed by the applicable plan, policy, or law.
- **Financial responsibility.** I understand that I am financially responsible for all charges not paid by insurance or another payer, including any deductibles, co-payments, co-insurance, non-covered services, denied claims, or amounts that exceed available benefits.
- **Release/use of information for claims and payment.** I authorize Valente Chiropractic PLLC to use and disclose the minimum necessary medical, billing, and claim information to insurance companies, claim administrators, attorneys, and their agents as needed to verify benefits, submit and process claims, coordinate benefits, obtain payment, pursue appeals, and determine benefits payable for related services.
- **Signature on file.** I authorize Valente Chiropractic PLLC to use my signature on file for Box 12 and Box 13 of paper or electronic health insurance claim forms, including authorization to release information necessary to process claims and to direct payment of medical benefits to Valente Chiropractic PLLC.
- **UCC / lien notice.** To the extent permitted by applicable law, I understand that Valente Chiropractic PLLC may file a UCC financing statement, lien, or other notice to seek direct payment from the listed insurance companies or claim payers. Such filing may be searchable as a public record and may include the minimum necessary information, such as my name, address, claim number, amount owed, payer name/address, and this assignment/release.
- **Changes in coverage or claim status.** I understand that if I open or re-open a claim, change insurance, or my coverage changes, I may need to complete a new assignment and release form.

SIGNATURE

By signing below, I agree to the terms above. If signing for the patient, I confirm that I have authority to act as the patient's parent, guardian, or personal representative.

Signature: _____ Date: _____

Printed Name: _____ Relationship/Authority, if not patient: _____

Patient Motor Vehicle Collision Billing Instructions

Should I not have PIP or Med Pay on my Auto Insurance Policy, or should PIP/MedPay deny coverage for some or all of my charges, or should I exhaust the limits of the PIP/Med Pay with my Auto Insurance Policy:

I, _____, instruct Valente Chiropractic PLLC to bill the following while I'm treating for injuries sustained from the motor vehicle collision that occurred on _____:

Option 1 : Bill Health Insurance

_____ ❑ Bill my health insurance carrier:
Health Insurance Name: _____
Member ID Number: _____

I understand that while billing my health insurance carrier, I will be responsible for paying my deductible, copays, co-insurance, and any non-covered charges as I treat. I understand that by selecting this option, **Valente Chiropractic will not wait until a settlement with a 3rd Party Auto Insurance Company for the collection of my portion of these charges**. I understand that I am responsible for all charges, whether or not paid by insurance.

Option 2 : Wait for Settlement - Lien on 3rd Party Settlement and/or Attorney's Lien

_____ ❑ I would like my charges to be paid upon settlement with a Third Party Auto Insurance Company. I understand that I will be signing a lien to help insure the payment of Valente Chiropractic's charges for services I receive.

Valente Chiropractic agrees to wait until settlement with the 3rd party Auto Insurance Company for collection of my treatment fees, unless it becomes apparent to Valente Chiropractic that no settlement is likely to occur.

Such reasons include, but are not limited to:

- Patient or their attorney stops communication with Valente Chiropractic and/or the 3rd Party Auto Insurance Company
- Patient is found or determined to be at fault for the motor vehicle collision.
- The 3rd Party Auto Insurance Company denies liability and the patient doesn't have an attorney that is working to contest this determination.

I am requesting that my health insurance not be billed. I understand that **my Health Insurance Carrier has a timely filing limit**, and that by requesting that Valente Chiropractic not bill my health insurance carrier, **I WILL NOT BE ABLE TO CHANGE MY MIND AND HAVE VALENTE CHIROPRACTIC RETROACTIVELY BILL MY HEALTH INSURANCE COMPNAY FOR THE SERVICES I RECIEVED, IF THIS TIMELY FILING LIMIT HAS PAST.**

I understand that I am ultimately responsible for the payment of my charges, regardless if they are paid out of a settlement or not. I understand that the 3rd party auto insurance company will not pay Valente Chiropractic's charges as I treat, but rather once a settlement agreement has been made, and that this settlement agreement will need to include payment for my charges at Valente Chiropractic. For this reason, I agree that I and/or my attorney will not settle with the 3rd Party Auto Insurance Company without first obtaining the full and final balance with Valente Chiropractic.

By signing below, I am agreeing that I fully read and understood the billing selection that I made above. I am agreeing that if I had any questions regarding my options, I asked them and was given an satisfactory explanation that addressed the ramifications of each option. I understand that I am considered to be “treating under the motor vehicle collision” per the doctor's judgment and that should I have chosen option 2, I must instruct Valente Chiropractic in writing if I want to begin billing my health insurance. I understand that Valente Chiropractic will not bill out any charges to my health insurance prior to the time the request to bill my health insurance is made.

Patient Signature: _____ Date: _____

LIEN

Authorization and Assignment

Patient's Name:_____ Attorney: _____

Date of Incident:_____ PIP/Med Pay:_____

3rd Party Auto Insurance:_____

- I hereby give a LIEN on my case to Valente Chiropractic PLLC, against any and all proceeds of my settlement, judgment or verdict which may be recovered or paid as the result of the injuries for which I have been treated.
- I authorize and direct my attorney to pay directly to Valente Chiropractic PLLC such sums as may be due and owing for medical services rendered to me both by reason of this incident and by reason of any other bills that are due and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate Valente Chiropractic PLLC.
- I authorize Valente Chiropractic PLLC to release any medical or other information to my attorney or the above listed insurance compan(ies) as the providers and/or staff at Valente Chiropractic PLLC deem necessary.
- In the event that I do not have an attorney, I authorize and direct the 3rd party auto insurance company listed above to pay Valente Chiropractic PLLC directly out of my settlement for the amount due for treatment rendered by the providers at Valente Chiropractic PLLC.
- I understand that I am directly and fully responsible to Valente Chiropractic PLLC for all medical bills submitted by them for services rendered to me. I further understand that such payment is not contingent on any recovery made by me.
- I understand that a UCC Financing Statement may be filed in order to perfect this lien. The UCC Financing Statement may include my name, address, claim number, monies owed, the relevant insurance company's name and address, my Assignment and Release, and this form. Copies of the UCC Financing Statement can be obtained from the Washington State Department of Licensing UCC Search.
- I have been advised that if my attorney does not wish to cooperate in protecting Valente Chiropractic PLLC's interest by signing this document, Valente Chiropractic PLLC will not await payment but may declare the entire balance due and payable.

_____ _____

Date Patient's Signature

_____

Patient's Printed Name

The undersigned attorney agrees:

1. To comply with the above “authorization and assignment”;
2. To withhold and pay directly to Valente Chiropractic PLLC from the above listed patient's proceeds from settlement, collection of judgment, PIP, med-pay or other insurance proceeds, the amount of Valente Chiropractic's charges, after contacting Valente Chiropractic PLLC for a current balance;
3. To notify Valente Chiropractic PLLC of any changes in the status of the claim which may preclude payment of Valente Chiropractic PLLC's charges;

_____ _____

Date Attorney's Signature

_____

Attorney's Printed Name