Personal Injury Authorization, Assignment, Contractual Lien & Letter of Protection

In consideration of Chiro One Wellness Centers ("COWC") undertaking to render care without immediate payment, I, on behalf of myself and any person I am the parent or legal guardian of ("dependents"), agree as follows:

HIPAA Authorization for Release of Information
I authorize COWC to use and disclose my protected health information (PHI) including medical records, bills, reports, narratives and payment information, to my attorney(s), insurers, claims adjusters, third parties involved in my injury claim concerning me or my dependent's treatment for the purposes of treatment, payment, claim resolution, lien enforcement, and legal proceedings. This authorization shall terminate upon the final resolution of my injury claim. I understand I may revoke this authorization in writing at any time and acknowledge that any disclosures made prior to such revocation in reliance on this authorization shall not be affected by such revocation.

Assignment of Benefits and Financial Responsibility
I hereby authorize, assign, and transfer to COWC any and all rights, claims, payments, recoveries or proceeds, I may have or obtain to receive direct payment from any person, insurer, payor (including but not limited to liability, med-pay, UM/UIM or health insurance), or parties and their representatives, arising from the injuries for which COWC rendered services to the extent of amounts owed to COWC. COWC reserves the right to determine the order of billing for all available coverages (including third-party liability, first-party auto, and health insurance) in accordance with state law and contractual obligations. I further authorize and direct any insurer, payor, attorney, or other third party to issue payment jointly to me and COWC and to withhold and remit to COWC the portion of any settlement, verdict or judgment necessary to satisfy the amounts owed to COWC regardless of how such recovery is structured or paid.

Contractual Lien & Letter of Protection
In consideration of treatment without immediate payment, I authorize and direct my attorney (if any), insurers, payors, or other third parties to withhold and pay directly to COWC from any settlement, verdict, or judgement the full amount due for the services rendered. I grant COWC a contractual lien against any recovery related to my injury claim, independent of any statutory lien rights which shall attach immediately upon execution of this agreement and shall apply to any recovery related to the injury claim, regardless of when or how obtained and shall remain in effect until COWC is paid in full. I authorize COWC to enforce this agreement, assignment, and lien directly against any responsible party solely to enforce payment of amounts owed for services rendered and not to control or direct the underlying injury claim.

Patient Financial Responsibility
I understand and agree to be personally financially responsible for all charges for services rendered regardless of the outcome of any claim or settlement. Regardless of any billing arrangement, I agree that I will be primarily responsible for all charges owed to COWC (other than those included in any pre-paid offer) for services rendered, including reasonable attorney fees, court costs, and other expenses of collection actually incurred in enforcing this agreement. I agree that if I receive any insurance or settlement proceeds directly for services rendered by COWC I will reimburse all such payments to COWC.

Patient Financial Acknowledgement
I understand that COWC requires updated information about me or my dependent's personal injury claim for the claim process, including, but not limited to, promptly:

1) Reporting the claim to all applicable insurers.
2) Providing all parties' names and addresses, insurer details, adjuster and attorney contact information and claim numbers.
3) Providing a copy of the police report.
4) Providing any correspondence from insurers regarding benefits or coverage determinations.

Name (Printed): _____ Signature: _____ Date: _____

PERSONAL INJURY PAPERWORK

Insurance Company / Attorney Certification

Patient:
If you do not have all of the information requested below, please call your attorney or insurance adjuster and have this form completed for your next visit. Request an additional form if more space is needed.

My Automobile/Premises
Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax:_____ _____

Has the accident been reported? ☐Yes ☐No

Name of Adjuster:_____ E-Mail:_____

Insured Name: _____

Date of Accident: _____ Claim #: _____

Med Pay – How much is available? _____ What's left? _____

The Other Party's Automobile/Premises
Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax:_____

Has the accident been reported? ☐Yes ☐No

Name of Adjuster:_____ E-Mail:_____

Insured Name: _____

Date of Accident: _____ Claim #: _____

My Health Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

ID #: _____ Group #: _____

Insured Name: _____

Phone: _____

My Attorney: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____E-Mail:_____

PERSONAL INJURY PAPERWORK

Personal Injury Questionnaire – Motor Vehicle Accident

Please describe how your injury occurred:

_____

_____

_____

Did the accident occur while you were at work? If yes, please indicate your employer's name:	☐Yes ☐No _____
Did another person cause the accident? If, yes, who:	☐Yes ☐No _____
If you responded "yes" to either of the above questions, do you intend to pursue a personal injury claim?	☐Yes ☐No
Where did the accident occur? (Please include city, state and zip code)	_____ _____
What was your involvement? If you were a vehicle passenger, where were you seated?	☐Driver ☐Passenger ☐Cyclist ☐Pedestrian ☐Front ☐Right-rear ☐Left-rear
From what direction was the impact?	☐Front ☐Rear ☐Left Side ☐Right Side
What were your approximate speeds at the time of impact?	You: _____mph Others: _____mph
What were the weather condition(s) at the time of the injury?	☐Dry ☐Wet ☐Snow / Ice ☐Other: _____
Were you moving or stopped?	☐Moving ☐Stopped
If your vehicle was shoved, in what direction did it move?	☐Forward ☐Backward ☐Sideways
If you were shoved, in what direction did you move?	☐Forward ☐Backward
Did any part of your body hit the interior of the vehicle or the ground? If so, which part of your body:	☐Yes ☐No ☐Windshield ☐Side door ☐Side window ☐Other: _____ ☐Chest ☐Head ☐Chin ☐Face ☐Right knee ☐Left knee ☐Other: _____
Were you holding on to the steering wheel?	☐Yes ☐No
Did the vehicle go into a spin/roll as a result of the impact? If yes, please explain:	☐Yes ☐No _____
At the point of impact, where did you experience pain? *(Please be specific)*	_____ _____
Immediately following the accident, which of the following best describes your state? If you lost consciousness, how long were you unconscious?	☐ Conscious ☐ Dazed ☐ Unconscious _____
Did you go to the hospital? If yes, when? How did you get to the hospital? If by ambulance, did the ambulance attendants place you in any of the following:	☐Yes ☐No ☐ Immediately ☐Next Day ☐Other: _____ ☐Ambulance ☐ Other: _____ ☐ Neck brace ☐ Back brace ☐Other: _____
If you were admitted into the hospital, please answer the following… Name of hospital: Name of doctor: Diagnosis: Treatment received:	_____ _____ _____ _____
Did you have any X-Rays taken at the hospital?	☐Yes ☐No
Did you have any other imaging taken at the hospital (MRI/CT)?	☐Yes ☐No
Were there any other medical supplies or medications given? If yes, what?	☐Yes ☐No _____
Have you had any similar problems before? If yes, please explain:	☐Yes ☐No _____
Have you lost any days of work from this injury? If yes, please list date(s):	☐Yes ☐No _____

_____	_____	_____
Name (*Printed*)	Signature (*Patient/Parent/Guardian*)	Date
_____	_____	_____
Witness Name (*Printed*)	Signature	Date