AUTO ACCIDENT PATIENTS

The following information is necessary for claims processing:

- Name and address of **your** vehicle insurance carrier
- Insurance Claim Number (assigned by **your** insurance company)
- Copy of **your** vehicle insurance card
- Copy of the vehicle accident report

Also, please know that as a formality, we will be sending a Notice of Physicians Lien to you and your vehicle insurance company. This ensures that your doctor is paid for their service on your behalf.

Thank you.

Please fill in the required info here:

Name of insurance: _____

Address of where to file claims: _____

Claim number: _____

Claims adjustor name and number: _____

Name of Policy Holder: _____ Date of Birth: _____

Address: _____

PATIENT/PHYSICIAN CONTRACT

I hereby authorize Acu-Care Total Health and/or its agents or employees to contact my insurer or other responsible third party to confirm my eligibility for reimbursement for services provided by this office. I understand and agree that the medical necessity and fees due for all services provided to me by this office will be determined by Acu-Care Total Health, and that payment in full for all such services is my own responsibility, regardless of any reimbursement arrangements between myself and any insurance plan or other third party involved in payments for my case. I authorize any such insurance plan or other third party to pay benefits directly to this office when a balance is due. I agree to remit directly to this office immediately upon request, any and all amounts due, and will be responsible for attorney's fees equal to one third of the outstanding balance due should legal collection proceedings be initiated to ensure my full compliance with this agreement. I further agree that, should I discontinue care on my own, I will be responsible for payment in full, any charges due Acu-care Total Health. I certify that all of the above information is current, true and correct to the best of my knowledge, and I will notify this office immediately of any changes in my health status or financial information.

Patient Signature:_____

Date:_____

ACCIDENT AND INJURY QUESTIONNARE AND ASSIGNMENT

Date of Injury:_____ Time of Injury:_____

Type of Accident or Injury: __ Auto __ Work Related _____Other

Where did the accident occur? _____

Describe how it happened:_____

_____

_____

If an auto accident:

Were you __driver __passenger __ pedestrian _____ other?

Did your car strike the other? __ Yes __ No

Did the other car strike yours? __ Yes __ No

Were you struck from: __ behind __ front __ left __ right?

Were traffic citations issued to: __ you __driver of your car __ driver of other car __ none

Have you contacted an attorney? __Yes __No

Name_____ Phone: _____

If a work injury:

Did you report this to your employer? __ Yes __ No

Did they recommend care at our office? __ Yes __ No

Are you right __ or left __ handed?

Describe in detail, any symptoms immediately following the accident/injury.

_____

_____

Have you had any of these symptoms before? __Yes __No If so, which ones? _____

_____

Describe any new symptoms since accident/injury:

_____

_____

Have you had a previous injury to the presently injured area?

__Yes __ No If so, how did it happen?_____

Have you lost any time from work? __ Yes __ No

Dates: From _____ through _____.

Were you hospitalized? __ Yes __ No If so, where? _____

Authorization to Use or Disclose Protected Health information

ACU-CARE TOTAL HEALTH

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, Acu-Care Total Health may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or associates of this office and :

- my attorney and/or insurance company

Patient Health Information authorized to be disclosed:

- for this injury only.

For the specific purpose of:

- treatment and payment.

Effective dates for this authorization: __/__/__ through __/__/__. This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reason beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____

Signature of Patient or Patient's Authorized Representative Date

_____ _____

Authorized Signature of Facility Date