Chart#_____

BAKKE CHIROPRACTIC

Auto Accident History Form

Patient Information

Last Name: _____ First Name: _____ M.I: _____

SSN: _____ - _____ - _____ Date of Accident: _____ Time of Accident: _____ AM/ PM

Accident Details

Were you the: Driver _____ Front seat passenger _____ Back seat passenger ____

Driver of vehicle (if not you): _____ Owner of vehicle: _____

Part of vehicle involved: Front _____ Rear _____ Driver side _____ Passenger side ____ Rolled vehicle _____

Road conditions: Icy _____ Snowy _____ Rainy _____ Wet _____ Clear/Dry _____

Did you see the accident coming? No _____ Yes _____ Did you brace for impact? No _____ Yes _____

Approx. speed of your vehicle: _____ MPH Speed of other vehicle: _____ MPH Were brakes applied? No _____ Yes _____

Were you wearing your seatbelt? No _____ Yes _____ Were you cut or bruised? No _____ Yes _____

Was your headrest even with? Your neck _____ Lower half of head _____ Upper half of head _____

Head position at time of impact: Turned right _____ Turned left _____ Looking up _____ Looking down _____ Looking forward ____

Body position at time of impact: Netural _____ Turned right _____ Turned left ____

Did any part of your body hit anything inside the car? No _____ Yes _____

Were the police called? No ____ Yes _____ If yes, was a police report done? No _____ Yes ____

Did the ambulance come? No ____ Yes _____ Were you evaluated? No ____ Yes _____

Describe what happened to you upon impact: _____

_____

Describe how you felt immediate after the accident: _____

Later that day: _____

The next day: _____

Treatment Details

Did you seek any treatment prior to today because of the accident? No _____ Yes _____ If yes, please explain: _____

_____

Were you taken off work or given any work restrictions because of the accident? No _____ Yes _____ If yes, please explain:

_____

Are you currently on any work restrictions? No _____ Yes _____ If yes, please explain: _____

_____

Prior to this accident have you ever been injured/ or had symptoms in the area now affected? No _____ Yes _____

If yes, please explain (be specific): _____

More on back of the page

Are your daily activities different since this accident? No _____ Yes _____ If yes, please explain: _____

_____

List **ALL** medical doctors, chiropractors, and physical therapists you have seen since the accident: _____

_____

Attorney Information

Have you retained an attorney? No _____ Yes_____

Attorney's Name: _____ Attorney's Phone #: _____

Your Auto Insurance Information

Insurance Company Name: _____

Policy Holders Name: _____ Policy Holder's Phone #: _____

Adjustor's Name: _____ Adjustor's Phone #: _____

Claim #: _____ Policy Number: _____

At Fault Party's Auto Insurance Information (If Applicable)

At Fault Insurance Company Name: _____

At Fault Party's Name: _____

Adjustor's Name: _____ Adjustor's Phone #: _____

Claim #: _____ Policy Number: _____

Patient/ Guardian Signature: _____ **Date:** _____

BAKKE CHIROPRACTIC

312 East North Street
DeForest, WI 53532
608/846-3333
608/846-7033 fax

725 West Main Street
Suite A
Sun Prairie, WI 53590
608/837-7600
608/837-0633 fax

612 East Main Street
Waunakee, WI 53597
608/849-9014
608/849-9015 fax

801 North Main Street
Lodi, WI 53555
608/592-1400
608/592-3063 fax

Insurance Company:

RE: Health Reports and Doctor's Lien For Direct Payment

I hereby authorize the above captioned doctor to furnish you, my Insurance Company and/or the Insurance Company representing the liable party, with a full report of examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my Insurance Company and/or the Insurance Company representing the liable party, to pay directly to said doctor such sums as may be due and owing him for professional services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment of verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my Insurance Company and/or the Insurance Company representing the liable party, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Dated: _____ Patient's Signature: _____

<u>If patient is a minor:</u>

Signature of Parent/Guardian: _____

Relationship to Patient: _____

The undersigned being the Insurance Company of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment of verdict as may be necessary to adequately protect the said doctor named above.

Dated: _____ Insurance Representative: _____

AUTOMOBILE INJURIES PAYMENT POLICY

Our Business Office will prepare, complete and submit claims to insurance carriers for provided services, and will respond to any inquires related to the processing of these claims. We rely on you to provide us with all current and applicable insurance information. You are responsible to fill out and return any inquiries sent to you by your insurance company. As a courtesy service to our patients, our Business Office will call your insurance carrier and verify your insurance coverage. This will not guarantee coverage or payment, but will inform you of the likely insurance coverage for your treatment.

When you have been injured in a motor vehicle accident, it is often not immediately clear who will be financially responsible for any injuries you receive. We have found, in most cases, that **your own auto insurance** will pay for your treatment costs (through the medical payment portion of your automobile insurance policy) and your insurance company will obtain any reimbursement due from **other insurance companies** or any other responsible parties at the time of settlement.

If this option (your insurance company's medical payment benefit) is not available, you must contact our Business Office to determine if third party insurance, or other health insurance coverage options are available. Our Business Office will also arrange for payment plan options if necessary. Our Business Office can be reached Monday through Friday from 8:00 am to 5:00 pm at (608) 846-3337.

AUTHORIZATION AND ASSIGNMENT

Furthermore, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim or reimbursement of charges incurred for services provided to me by you or any member of your staff acting on your behalf.

2. I authorize the direct payment to you of any sum I now or hereafter owe you, by any insurance company or by my attorney out of the proceeds of any settlement of my case.

3. **I understand that whatever amount you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.**

_____ _____

Patient/ Guardian Signature Date

_____

Date of Injury

I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

Bakke
Chiropractic Clinic

312 East North Street
DeForest, WI 53532
608/846-3333
608/846-7033 fax

725 West Main Street
Suite A
Sun Prairie, WI 53590
608/837-7600
608/837-0633 fax

612 East Main Street
Waunakee, WI 53597
608/849-9014
608/849-9015 fax

801 North Main Street
Lodi, WI 53555
608/592-1400
608/592-3063 fax

Regarding your recent accident

Thank you for choosing the Bakke clinic for treatment for your recent car accident injury. We are committed to working with you and your insurance company. We rely on you to provide us with the most current insurance information. If you have not already done so, please contact your insurance company and report this injury. It is important that you do this within 24 hours of your first visit to our clinic.

Our Business Office will be contacting the insurance company that you provided to us to verify where we are to send the claims and to get the claim number assigned to your case. Also, we would like to review our payment policy with you:

> "When you have been injured in a motor vehicle accident, it is often not immediately clear who will be financially responsible for any injuries you received. We have found, in most cases that your own auto insurance will pay for your treatment costs (through the medical payment portion of your automobile insurance policy) and your insurance company will obtain any reimbursement due from other insurance companies or any other responsible parties at the time of settlement."
>
> "If or when your account comes to a point where the maximum benefits of the med-pay portion of your insurance has been met and you (or your attorney) are going to wait for settlement of your account with the 3rd party insurance, Bakke clinic will request to bill your health insurance or ask you to set up a payment plan. These options will be discussed between you and a representative of our Business Office or your doctor."

Also, please contact our business office if any insurance information changes through the course of your treatment. Our Business Office can be reached Monday through Friday from 8:00 am to 5:00 pm at (608) 846-3337.

Thank you.

Bakke Clinic Business Office