

NAME _____ DATE _____ DOB _____ AGE _____

DATE OF ACCIDENT _____ STATE ACCIDENT OCCURRED _____

WHERE WERE YOU SEATED INSIDE THE VEHICLE (please circle) driver front passenger
left rear passenger center rear passenger right rear passenger motorcycle bicycle pedestrian

DESCRIBE VEHICLE YOU OCCUPIED (please circle) car van truck SUV bus motorcycle other

WHAT DIRECTION DID THE IMPACT COME FROM? (please circle) the front the rear the right the left

YOUR SPEED AT IMPACT _____ mph _____ stopped

DAMAGE TO YOUR VEHICLE (please circle) minimal moderate extensive totaled unsure

WAS POLICE REPORT FILED _____ yes _____ no

DESCRIBE VEHICLE THAT COLLIDED WITH YOUR VEHICLE (please circle) car van truck SUV bus motorcycle other

THE SPEED OF OTHER VEHICLE AT IMPACT _____ mph

DAMAGE TO OTHER VEHICLE (please circle) minimal moderate extensive totaled unsure

AT IMPACT WHERE WERE YOU LOOKING (please circle) straight ahead left right down over shoulder

WEARING SEATBELT _____ yes _____ no

AIR BAG DEPLOYED _____ yes _____ no

PREPARED FOR ACCIDENT _____ yes _____ no

BODY IMPACT (please circle) head face left shoulder right shoulder left arm right arm left elbow
right elbow left hand right hand chest upper back mid back lower back left leg right leg left knee
right knee left foot right foot

WAS THERE A THIRD IMPACT (please circle) another vehicle tree fence ditch other _____

AFTER ACCIDENT INFORMATION

IMMEDIATELY AFTER ACCIDENT (please circle) dizzy dazed upset weak nervous disoriented unconscious

DID YOU SEEK MEDICAL CARE _____ yes _____ no same day next day within week within month

TRANSPORTED TO MEDICAL CARE BY(please circle) self friend family member ambulance

WHERE DID YOU SEEK MEDICAL CARE (please circle) ER primary care Dr urgent care orthopedic chiropractor

WHAT TESTS WERE PERFORMED (please circle) X-rays MRI CT scan lab work none

TREATMENTS RECEIVED (please circle) medication orthotic bracing ice pack hot pack none

GENERAL SYMPTOMS SINCE ACCIDENT (please circle) nervousness irritability fatigue depression anxiousness
sleeplessness weight loss weight gain

HAY CLINIC OF CHIROPRACTIC, P.A.

927 Cox Road

Gastonia, N.C. 28054

(704) 824-4463

ASSIGNMENT OF PROCEEDS, LIEN, AND AUTHORIZATION

I hereby authorize and direct any and all insurance carriers, attorney's, agencies, governmental departments, companies, individuals, and/or other legal entities ("payers"), which may elect or be obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future ("condition") to pay directly and exclusively in the name of Hay Clinic of Chiropractic, P.A. such sums as may be owing to Hay Clinic for charges incurred by me which relate, directly or indirectly, to my condition ("charges"), with such payments to be made exclusively in the name of Hay Clinic of Chiropractic, P.A. I further grant a lien to Hay Clinic with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law. For the purposes of this Assignment, Lien, and Authorization (herein, "Agreement"), "benefits" shall include, but not be limited to, proceeds from any settlement, judgement, or verdict, as well as any proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purpose stated herein.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office.

I authorize Hay Clinic to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I further authorize and direct all payers to release to Hay Clinic any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I hereby direct Hay Clinic to file a copy of this agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Hay Clinic to endorse/sign my name on any and all checks listing me as a payee which are presented to Hay Clinic for payment of an account relating to me, my spouse, or any of my dependents. I further authorize Hay Clinic to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

(Continued)

I understand that I remain personally responsible for the total amounts due Hay Clinic for their services. This Agreement does not constitute any consideration for Hay Clinic to await payments and it may demand payments from me immediately upon rendering services at its option. If Hay Clinic must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Hay Clinic for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of Hay Clinic and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of Hay Clinic and myself. However should any provision of this Assignment be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provision of this Assignment shall, nevertheless, remain in full force and effect.

Patient Name (please print) _____

Patient Signature _____

Date _____

Custodial Parent or Legal Guardian (please print) _____

Parent/Guardian Signature _____

Date _____