

Frederick Chiropractic Wellness Center

Dr. Deborah Morrone

425 E. Patrick Street, Frederick, MD 21701 • 301-695-0032 • 301-695-3911 fax

AUTO ACCIDENT INFORMATION

NAME _____ TODAYS DATE _____

DATE OF ACCIDENT _____ TIME _____ LOCATION _____

Were you the: Driver Front passenger Left rear passenger Right rear passenger Pedestrian

What make/model car were you riding in at the time of the accident? _____

What make/model was the other involved car? _____

At the time of impact, was your vehicle stopped in motion If moving, estimate how fast? _____

Approximately how fast was the other car moving at the time of impact? _____

Were you hit from the Front Left side Right side Rear Other _____

Which direction were you looking at the time of impact? Forward Left Right Down Other _____

Were your hands on the steering wheel at the time of impact? Y N Don't recall

Were you wearing your seat belt? Y N Were you: Prepared for impact Caught by surprise?

Did the airbag deploy? Front Y N Side Y N

Did the vehicle flip over? Y N Were you thrown out of your seat? Y N

Which objects in the vehicle did your body strike (Specify the body part that made contact)

steering wheel door headrest dashboard other _____

Describe, in detail, how the accident occurred: _____

Were the police notified? Y N Was a police report made? Y N Do you have a copy? Y N
(Please provide us with a copy of the police report for our records)

How much damage did your vehicle sustain? minimal moderate extensive total \$ _____

Did you feel immediate pain? Y N If yes, where? _____

If not, when did symptoms begin? _____ Explain: _____

Did you receive any cuts or bruises? Y N If yes, where? _____

Did you lose consciousness? Y N If yes, for how long? _____

Where did you go after the accident ER Urgent Care Home School Work Other _____

Were you : taken by ambulance driven by another person able to drive yourself

Have you had Xrays MRI CT Scans Other tests _____

Where were these tests done? _____ Date _____

List diagnosis and treatment received _____

Has any other Dr. been consulted? Y N Name _____ Date _____

What treatment/medications were given? _____

How often did you see the doctor? _____ Are you still seeing him/her? Y N

For what problems are you seeking treatment? _____

Have you ever had similar symptoms or injuries before? Y N Explain _____

Have you ever had any prior accidents or injuries? Y N Explain? _____

Are you presently working? Y N What is your occupation? _____

Employers Name/Address _____

What are your job duties? _____

Have you lost any time from work or school since the accident? Y N Dates: _____

Is there anything else that we should know about your accident, past history, and/or injuries? _____

INSURANCE COVERAGE

Did the auto accident occur while working on the job? Y N

Has the accident been filed as Worker's Compensation? Y N Claim # _____

Employer's name and address: _____

LIABILITY INFORMATION

Who was cited as the liable driver (person responsible for the accident)? _____

Was insurance information exchanged at the accident? Y N (*please provide a copy for our records*)

Has the accident been reported to the liability insurance company? Y N

Insurance Carrier: _____ Phone: _____

Name of Insured: _____ Policy # _____ Claim# _____

Name of Adjuster: _____ Phone _____

Have you opened a PIP (Personal Injury Protection) claim? Y N Claim # _____

Has the liability carrier paid for your vehicle damage? Y N

ATTORNEY REPRESENTATION:

Have you retained an attorney? Y N Name: _____ Phone# _____

Address: _____

PERSONAL HEALTH INSURANCE

(Please provide the front desk with a copy of your card)

Carrier _____ Policy# _____ Group # _____

Insured's Name _____ DOB _____ Relationship _____

I verify that the information provided above is accurate and complete.

PATIENT NAME: _____ DATE: _____

SIGNATURE _____

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Dr. Deborah Morrone
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www.frederickchiro.com

AUTO ACCIDENT OFFICE POLICY

The following details our office policies and available payment options for auto accident related cases.

PERSONAL INJURY PROTECTION (PIP)

Patient Initials _____

Upon verification of benefits, we will file all insurance claims to both insurance sources. The PIP portion of your auto insurance policy will be filed weekly throughout care. *Filing to your PIP should not affect your coverage or rates, and is a benefit that you are entitled to receive.* In the case that your PIP does not cover the cost of all of your treatment, the Liability Insurance (of the person responsible for the accident) will be filed. *It is your responsibility to provide us with any and all PIP and Liability information. If this information is not received by your third visit, you will be asked to pay for each visit in full.*

ATTORNEY REPRESENTATION

Patient Initials _____

If you are represented by an attorney, we will hold a signed lien on payments up to our full fees, and will also file to PIP, if available. If our fees are reduced in the settlement, for any reason, you may be responsible for the remaining balance, up to our full fees. If a settlement has not been made within 6 months after your discharge from care, your account balance becomes payable in full, and we will discuss payment options at this time. **Please note:** In order for us to file on your behalf, you must sign a Lien and Assignment of Benefits, which will be remitted to the insurance companies and attorney. This confirms that payment will be made in full, directly to our office. If any payments are mailed directly to you, they are to be forwarded to our office upon receipt. Receipts or account statements will not be provided to a patient until the account balance has been paid in full, either by the insurance company or the patient. **If you choose to suspend or terminate your care, any fees for services rendered become immediately payable in full .**

PERSONAL HEALTH INSURANCE

Patient Initials _____

If PIP insurance is not available, we will also file to your health insurance company (upon verification of benefits) if they do not have the right of subrogation (the right to request a refund if the Liability company pays.) Because this is a third party case, any contract between us, the provider, and your health insurance company will be waived. After all insurance processing is completed, you are responsible for any remaining balance. Any and all overpayments will be refunded to you.

I have read, understand, and fully agree to the terms and conditions as stated above. I have signed my initials next to the payment option that I have chosen. I have signed the Assignment of Benefits and Liens, and I understand that I am ultimately responsible for full payment for services rendered by Frederick Chiropractic Wellness Center, Inc. and Dr. Deborah Morrone.

PATIENT NAME _____ **DATE** _____

SIGNATURE _____

Frederick Chiropractic Wellness Center

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www.frederickchiro.com

DOCTOR'S LIEN

To: ATTORNEY LIABILITY INSURANCE CARRIER OTHER _____

NAME: _____

ADDRESS: _____

PHONE: _____

FROM: Frederick Chiropractic Wellness Center, Inc.
 Dr. Deborah Morrone
 425 East Patrick Street
 Frederick, MD 21701

I do hereby give a lien to above doctor on any settlement, claim, judgment, or verdict as a result of my accident/illness, which occurred on _____.

I authorize and direct you, _____ to pay directly to said doctor any/all sums that may be due for any/all services rendered to me. I authorize you to withhold such sums from any settlement, claim, judgment, or verdict, and to protect said doctor adequately.

I understand that I am directly and fully responsible to said doctor for any/all services billed by him/her rendered to me, and that this agreement is made to further protect the doctor's reimbursement of services rendered and in consideration of his/her awaiting payment.

I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict that I may eventually may recover. This lien shall be irrevocable, until such time that all of the doctor's bills have been paid in full.

PATIENT'S NAME: _____ DATE: _____

PATIENT'S SIGNATURE: _____

WITNESS: _____

CONFIRMATION OF RECEIPT AND COMPLIANCE

The undersigned, being the attorney of record or an authorized representative of insurance carrier, for the above patient does hereby acknowledge receipt of above lien, and does agree to honor this lien to protect the above named doctor, as detailed.

NAME OF AUTHORIZED REPRESENTATIVE: _____

AUTHORIZED SIGNATURE: _____ DATE _____

Please date, sign and return original copy to the doctor's office at address shown above. Please make a copy for your records.