ROSEMONT CHIROPRACTIC CENTER

Rosemont Chiropractic Center
397 Little Neck Road
Building 3400 • Suite 108
Virginia Beach, VA 23452

Name:________________________ Date of Accident:__________
Where did the accident happen: ____________________________
Describe the accident in your own words: __________________
____
What was your position in the car: Driver ___ Passenger ___
If passenger,were you in the: Front___ right rear____ left rear___
Did your vehicle strike another vehicle? Yes ___ No ___
Was your car struck by another vehicle? Yes ___ No ___
Was the impact from the: Front__ Right side__ Left side __ Rear__
At time of impact, were you looking: Left___ Right ___ Forward___
Were both hands on the steering wheel? Yes ___ No ___
Was your foot on the brake? Yes ___ No ___
Were you braced for impact? Yes ___ No ___
Where in the car were you after the accident? _____________
Were you wearing your seat belt? Yes ___ No ___
Did you strike anything in vehicle at time of impact? Yes __ No __
If yes, specify: Steering wheel ____ Dashboard ___ Windshield ___
Side door _____ Arm rests ____ Side window ____
Please state part of body: Chest ___ Chin ___ Knee ___ Hand ___
Shoulder ___ Head ___
Immediately following the accident, how did you feel?
____
Were you unconscious?_______ In a daze?_______
Did you go to the hospital? ______ If so, when? ________
How did you get to the hospital? Ambulance ___ Private vehicle ___
Name of hospital:____
Attended by Dr.__________ Were you x-rayed? Yes ___ No ___
If so, what was the diagnosis? ____________________________
Were you admitted to the hospital? Yes___ No___ For how long?____
What treatment was rendered? ______________________________
What recommendations were made? ___________________________
____
What other doctor did you see after the accident? _________
What treatment was rendered? ______________________________
What recommendations were made? ___________________________

For the following, check all that apply:
Is your pain: Constant ____ On and off _____ Sharp ___ Dull _____
Other ____
Is your pain made worse: By coughing _____ By sneezing _____
When arising from a chair ___ By straining when moving bowels___
Other ____
Do you have numbness or tingling in your: Arms ____ Hands _____
Fingers _____ Legs _____ Feet ____ Toes _____ Other _____
What is your most comfortable position? Sitting ___ Standing ___
Lying on your: Right side ___Left side ___ Back ___ Stomach ___
Other ____

Is it difficult to move around in bed? Yes ___ No ___
Does stretching and twisting worsen the pain? Yes ___ No ___
Do any of the following relieve your pain: Heating Pad ___
Hot bath ___ Shower ___ Ice Pack ___ Brace ___
Do you feel better: Moving around ______ Resting ___

Have you lost any time from work because of this accident? _____
If yes, give dates of time lost. From ____________ to __________
Specify why you are unable to return to work at this time: ______
____
Number of people in your vehicle ___ Were they wearing seat belts? _______

Did you have any physical complaints before the accident: Yes ___ No ___ If yes, please describe in detail: ___________________________
____
Have you ever been involved in an accident before? Yes ___ No ___
If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received ____________________
____
____

Did you have car insurance at the time of this accident? Yes/No
If yes, what is the name of the company and policy number? ______
____
Have you reported the accident to them? Yes/No If yes, what is the claim number or adjustor's name? __________________________
____
Did the person who hit you have car insurance? Yes/No If yes, what is the name of the company? ___________________________
Do you have med-pay on your insurance policy? Yes/No
Have you retained an attorney? Yes/No If yes, what is his/her name? ____________ Address/phone number ____________
____

IF YOU DO NOT HAVE ALL OF THIS INFORMATION WITH YOU, PLEASE BRING IT WITH YOU ON YOUR NEXT VISIT.

IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORIZATION AND LIEN

To Whom It May Concern:

This Irrevocable Assignment of Benefits, Authorization and Lien (this "Assignment") is made by and between _______________ ("Patient") and ________________ ("Health Care Provider"). With this Assignment, and in consideration of treatment without having to render concurrent payment, Patient, hereby irrevocably transfers sets over and assigns to Health Care Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the Patient by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorneys' fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to Patient or on Patient's behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patient's favor as may be necessary to fully pay any and all financial obligations owed to the HealthCare Provider by the Patient. This Assignment is to be a complete and current transfer of Patient's right, title and interest, separate from any statutory or contractual lien or claim to which the Health Care Provider may also be entitled. Patient acknowledges that Health Care Provider has a substantial pecuniary interest in the enforcement of this Assignment.

The Patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all of the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Provider's total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Health Care Provider any and all causes of action that Patient might have or that might exist in Patient's favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates and appoints as Patient's attorney-in-fact any officer of the Health Care Provider, to prosecute said causes(s) of action either in Patient's name or in the Health Care Provider's name and Patient further authorizes the Health Care Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Health Care Provider, Patient hereby grants a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Health Care Provider. The Patient further agrees that the statute of limitations applicable to Health Care Provider's right to demand payment from the Patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing.

Patient hereby acknowledges that Virginia law imposes a lien in the amount of $750.00 upon Patient's claim against the individual or entity whose negligence is alleged to have caused Patient's injuries.

Notwithstanding the foregoing, the Patient agrees that until the Health Care Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due the HealthCare Provider (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The Patient further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect of payment, it may demand payments from Patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

Patient authorizes the Health Care Provider to release this Assignment and any information pertinent to Patient's case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Health Care Provider as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of any indebtedness owed by Patient to the Health Care Provider and to negotiate same for payment of the services provided to Patient by said Health Care Provider.

In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect.

Witness the following signatures and seal as of the indicated date:

Patient:
Signature____ (SEAL)
Printed Name______________________________________
Date____________ SS#________________________

Witness________________________________

Health Care Provider:

____
By: ____________________________
Its: ____________________________
Date ________________

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After being explained the benefits of using my health insurance, I have decided not to have my provider bill my insurance. I understand I have the right to refuse this decision at any point, but that should I choose to re-instate my coverage I will be responsible for all uncovered service.

Print name: ______________________________

Signature: ________________________________

Parent or guardian signature (if under the age of 18)

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