Automobile Accident Information

Patient Name _____ Date _____

Date of Accident _____/_____/_____ **Location of the accident**_____

Give a brief description of the accident:

In which direction were you traveling? N S E W

Estimated speed of your vehicle_____ Estimated speed of other vehicle_____

Were seatbelts worn? Y / N Seatbelt was a: Lap belt only / Lap belt with shoulder harness / Other_____

Position in vehicle: Driver / Front (**Right Middle**) Passenger / Rear (**Right Middle Left**) Passenger / Pedestrian

What type of vehicle were you driving?

Compact car Mid-size car Full size car Compact truck Full size truck Mini van Full size van

Compact SUV Full size SUV Motorcycle Motorhome Bicycle

How many vehicles were involved? _____

Who struck who? Was struck by another vehicle I struck another vehicle I struck a stationary object

What type of vehicle was the other vehicle?

Compact car Mid-size car Full size car Compact truck Full size truck Mini van Full size van

Compact SUV Full size SUV Motorcycle Motorhome Bicycle

What was your vehicle's point of impact?


Front

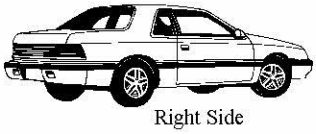

Right Side

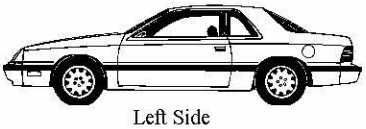

Left Side


Rear

What was the other vehicle's point of impact?


Front


Right Side


Left Side


Rear

The top of the headrest was aligned with the **Top** / **Middle** / **Bottom** of your head

Were your brakes applied? Y / N Were you at a complete stop? Y / N Were you braced for impact? Y / N

Did you vehicle's air bag deploy? Y / N

Did you see the collision coming? Y / N

Did you brace for impact? Y / N

What position was your body in just prior to impact?

A straight position Tilted forward Rotated to the right / left Other_____

In what direction were you looking?

Straight ahead To the right To the left Other_____

Have you been involved in any previous auto accidents? Y / N

If yes, please give the date and a brief description of the accident_____

_____

If you answered yes to the previous question, did you receive treatment? Y / N

Doctor_____ Length of time treated_____

Doctor_____ Length of time treated_____

Ray Chiropractic Center, PLLC

Richard S. Ray, D.C.
62 N Stapley Dr
Mesa, AZ 85203
(480)964-1234

Patient Name _____

I, _____, understand that it is my responsibility to provide **Ray Chiropractic Center, PLLC / Richard S. Ray, D.C.** with any information necessary to bill my attorney/insurance company. I authorize and assign my attorney/insurance carrier or it's intermediaries to issue payment checks directly to this office for services rendered. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. If it is ever necessary for **Ray Chiropractic Center, PLLC / Richard S. Ray D.C.** to employ collection counsel, I understand that I am responsible for all collection charges.

X_____ _____
Patient Signature Date

Dr. Richard S. Ray has agreed to accept my auto accident on a lien basis. I understand that an official county lien may or may not be filed. I understand that it may be necessary for this office to disclose some personal information in the process of filing a county lien and give **Ray Chiropractic Center, PLLC** permission to do so. I am also aware that county liens are public records.

If I have "**medical coverage**" under my own personal auto insurance policy I agree to file a claim and use this insurance, this will allow **Dr. Ray** to receive payment as I receive treatment for my injuries. I understand that this coverage may or may not pay my account in full thus I am responsible for any balance that may remain on my account at the end of my treatment. I understand there will be no negotiating of my balance if my medical coverage pays my bills in full. I also understand that by not notifying this office of possible medical coverage I will not be eligible for any possible reductions.

My **health insurance** may or may not be billed depending on my insurance and the contract that **Dr. Ray** has with the insurance company. Depending on my insurance company I understand that **Dr. Ray** may not be obligated to write-off certain contracted amounts that may normally be written off. This means that if Med Pay is available we are entitled collect the full amount due, not the discounted insurance price. I also understand that there is a time limit for filing claims with health insurance companies, therefore I agree to give **Dr. Ray** any health insurance information at the beginning of my treatment in order to get any necessary authorizations and to submit claims in a timely manner.

****It is my responsibility to verify the balance of my account when my case settles, if there is a balance due on my account, I agree to issue payment in full within 10 days of receiving my settlement payment. ****

I have read, understand and agree to honor the above statements.

X_____ _____ _____
Print Patient's Name Patient's Signature Date