ZINK CHIROPRACTIC CENTER

2117 Taylor Road
Montgomery, AL 36117

NOTIFICATION OF NON-COVERED SERVICES

Patient Name	Address	Phone
		Home
		Cell

Social Security Number	
Driver License State & Number	

As your physician, I want to provide you with the best care possible. There are services that I feel are necessary for the treatment of your condition and maintenance of good health that are not covered by your Blue Cross and Blue shield of Alabama or other health benefits contract. You are expected to pay for those services in full.

Let me reassure you that I will order only the tests and treatments that I feel are necessary for your treatment and care. If you have any questions about whether or not a particular service is covered by your health benefits contract, someone in our office will be happy to assist you. Thank you for your understanding.

Non-Covered Service(s)	Fees
Range Of Motion Study	$86 - $258
Ice Pack	$20
Cervical Pillow	$50
Therapies	$27 - $34

*I have read your policy and agree to pay for the services outlined above that are not covered by my contract as indicated by my signature for each date above.

Signature: _____ Date: _____

Direction to Pay

Date: _____

Auto Insurance Company: _____

ATTN: Claims Adjuster: _____

Adjuster Telephone: _____ Adjuster's Fax: _____

RE: DIRECTION OF PAYMENT for _____
Patient's Name Printed

Claim Number: _____

I, _____ authorize and agree that the above insurance company has my
Patient's Name Printed

permission and direction to pay Zink Chiropractic Center **DIRECTLY** for my treatment charges rendered due to the accident on _____, as indicated by my signature below.

_____
Patient's Signature

Sincerely,

Kim Riddle
Records/Billing

Direction to Pay

Date: _____

Auto Insurance Company: _____

ATTN: Claims Adjuster: _____

Adjuster Telephone: _____ Adjuster's Fax: _____

RE: DIRECTION OF PAYMENT for _____
Patient's Name Printed

Claim Number: _____

I, _____ authorize and agree that the above insurance company has my
Patient's Name Printed

permission and direction to pay Zink Chiropractic Center **DIRECTLY** for my treatment charges rendered due to the accident on _____, as indicated by my signature below.

_____
Patient's Signature

Sincerely,

Kim Riddle
Records/Billing

Letter of Protection

Patient's Name: _____ Attorney's Name: _____

Social Security Number: _____ Address: _____

Date of Loss: _____ _____

Telephone: _____

I hereby authorize and direct you, my attorney, to pay directly to Dr. Yolonda H. Zink or Dr. Thomas V. Zink such as may be due and owing this Office, and to withhold such sums from any disability benefits, or any insurance benefits, no-fault benefits, health and accident benefits, workman's compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment, or verdict on my behalf as may be necessary to adequately protect said Office. I hereby further give a lien to said Office against any and all insurance benefits named herein, any and all proceeds from any settlement, judgment, or verdict which may be paid to me as a result of the injuries or illnesses for which I have been treated by said Office. This is to act as an assignment of my rights and benefits to the extent of the said Office's services provided.

In the event my insurance company obligated to make payments to me upon the charges by this office for their services refuses to make such payment, upon demand by me or this Office, I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to comprise, settle, or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amount due the office for their services. I further understand and agree that this agreement, lien and authorization does not constitute any consideration for the office to await payments and they may demand payments from me immediately upon rendering services at their option. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I agree to pay all costs of collection of any balances due to this office, including reasonable attorney fees.

I authorize the Office to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this assignment, lien, and authorization. I agree that the above mentioned Office be given the Power of Attorney to endorse/sign my name on any and all checks for payment of my treatment bill. I, hereby instruct that in the event another attorney is substituted in the matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him. A photocopy of this agreement shall be considered as effective and valid as the original.

Patient Signature: _____ Date: _____

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

Attorney Signature _____ Date: _____

Personal Injury Questionnaire

Name _____ Date of Accident _____ Time _____
Where did accident happen? _____
Describe the accident in your own words: _____
_____
_____

Were you the: ☐Driver ☐Passenger If passenger, were you sitting in: ☐Front ☐Right rear ☐Left Rear
Was your car struck by other vehicle? ☐Yes ☐No Did your car strike other vehicle? ☐Yes ☐No
Was citation issued? ☐Yes ☐No If so, who received it? ☐Other driver ☐Me
Was the impact from the: ☐Front ☐Right Side ☐Left Side ☐Rear
At the time of impact, were you looking: ☐Straight Ahead ☐Right ☐Left
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 seat belts? ☐Yes ☐No Did air bag inflate? ☐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 ☐Other _____
What Part of your body: ☐Chest ☐Chin ☐Knee ☐Shoulder ☐Hand ☐Head ☐Other _____
Immediately following the accident: Were you unconscious ☐Yes ☐No In a daze ☐Yes ☐No
Did you go to hospital ☐Yes ☐No If yes, ☐Immediately ☐Next Day
How did you get to hospital? ☐Ambulance ☐ Private Transportation
Did attendants place you in ☐Neck Collar ☐Splint ☐Brace Name of Hospital _____
Attended by Dr. _____ Were you x-rayed ☐Yes ☐No What was the diagnosis _____
Were you admitted into the Hospital ☐Yes ☐No How long did you stay _ _____
What treatment was rendered? _____
What recommendations were made? _____
Have you lost any time from work due to this accident? ☐Yes ☐No
If yes, give dates of lost time: From _____ To _____
Do you feel that you cannot perform any physical work activity? ☐Yes ☐No
Do you feel that you cannot perform any mental work activity? ☐Yes ☐No
Do you believe that your inability to perform these functions are due to: ☐Pain ☐Weakness ☐Nerves
Do you have normal sexual function? ☐Yes ☐No
Have you seen any other doctor as a result of this accident? ☐Yes ☐No Doctors Name _____
Is your pain ☐Constant ☐On and Off ☐Sharp ☐Dull ☐Other _____
Is pain made worse by ☐Arising From A Chair ☐Straining ☐Coughing ☐Sneezing ☐Straining when Moving Bowels
Do you have any numbness or tingling in your: ☐Arms ☐Hands ☐Fingers ☐Legs ☐Feet ☐Toes
Most comfortable position is: ☐Sitting ☐Lying on Right Side ☐Lying on Left Side ☐Standing On Back ☐On Stomach
Does stretching or twisting worsen the pain? ☐Yes ☐No Is it difficult to move around in bed? ☐Yes ☐No
Do any of the following relieve the pain? ☐Heating Pad ☐Hot Bath ☐Shower ☐Ice Pack ☐Moving Around ☐Resting
Are you able to take care of your personal self? ☐Yes ☐No
Do you feel your present condition is: ☐Temporary ☐Permanent

Please Check Your Ability To Perform These Functions Both Before And After The Accident

		Before	After		Before	After		Before	After		Before	After
Walking	Normal	☐	☐	Limited	☐	☐	Difficult	☐	☐	Pain	☐	☐
Standing	Normal	☐	☐	Limited	☐	☐	Difficult	☐	☐	Pain	☐	☐
Sitting	Normal	☐	☐	Limited	☐	☐	Difficult	☐	☐	Pain	☐	☐
Bending	Normal	☐	☐	Limited	☐	☐	Difficult	☐	☐	Pain	☐	☐
Stooping	Normal	☐	☐	Limited	☐	☐	Difficult	☐	☐	Pain	☐	☐
Lifting	Normal	☐	☐	Limited	☐	☐	Difficult	☐	☐	Pain	☐	☐
Pushing	Normal	☐	☐	Limited	☐	☐	Difficult	☐	☐	Pain	☐	☐
Pulling	Normal	☐	☐	Limited	☐	☐	Difficult	☐	☐	Pain	☐	☐
Climbing	Normal	☐	☐	Limited	☐	☐	Difficult	☐	☐	Pain	☐	☐
Reaching	Normal	☐	☐	Limited	☐	☐	Difficult	☐	☐	Pain	☐	☐
Gripping	Normal	☐	☐	Limited	☐	☐	Difficult	☐	☐	Pain	☐	☐
Kneeling	Normal	☐	☐	Limited	☐	☐	Difficult	☐	☐	Pain	☐	☐
Balance	Normal	☐	☐	Limited	☐	☐	Difficult	☐	☐	Pain	☐	☐
Fatigue	Normal	☐	☐	Limited	☐	☐	Difficult	☐	☐	Pain	☐	☐

Patient's Signature _____ **Date** _____

Patient Insurance Profile

Patient Name _____ Date of Accident _____

Legal representative _____ Rep. phone # _____

Total # of vehicles in accident _____

I was ☐Driving ☐Passenger IN ☐My own car ☐Someone else's car

☐I was given citation for being at fault ☐The other driver was given citation for being at fault

YOUR AUTO INSURANCE COMPANY INFORMATION:

Insurance Company Name _____

Phone # _____ Fax # _____

Address _____

Claim # _____ Adjusters Name _____

I have Med Pay on my policy ☐Yes ☐No Limits _____

YOUR HEALTH INSURANCE INFORMATION:

Insurance Company Name _____

Phone # _____ Fax # _____

Address _____

Policy # _____ Limits _____

ADVERSE AUTO INSURANCE COMPANY INFORMATION:

Insurance Company Name _____

Phone # _____ Fax # _____

Address _____

Claim # _____ Adjusters Name _____