Personal Injury Form

1501 Hwy 18 Byp Ste B, Hot Springs, SD 57747

Patient Name:____ Date:_______________

1. Date of accident:____________________ Location (city, state):_____________________________
2. Were you the Driver or Passenger:__________________ If Passenger where were you sitting:____________________________
3. What type of vehicle were you in:______________________ What type was the other Vehicle:___________________________
4. Describe the accident in your own words:____

____

5. Were you shoved forward? Y N Whipped backward? Y N
6. Did your head hit the head rest? Y N Any other part of your body hit the car's interior? Y N

   If yes explain:____
7. At the time of the accident where did you feel pain:____

____

8. Did you go to the hospital? Y N If yes where at: ___________________________ When:_____________________________
9. Did you go by ambulance? Y N Were x-ray or other images taken? Y N Have you lost any days of work? Y N
10. Do you have an attorney? Y N If yes please list who and their phone number:_____________________________________
11. Do we have permission to speak with your attorney regarding your case? Y N
12. Who was the "at fault party": ____________________________________
13. Do you have a copy of the police report with you today? Y N (If no please bring us a copy as soon as possible)

Patient or parent Signature: ____ Date:__________________

Witness:____ Date:___________________

IRREVOCABLE ASSIGNMENT OF HEALTH-CARE INSURANCE RECEIVABLES
UNDER ARTICLE 9 – SECURED TRANSACTIONS –
UNIFORM COMMERCIAL CODE (SDCL CHAPTER 57A-9) and
AUTHORIZATION TO RELEASE HEALTH-CARE INFORMATION

TO: _________________________________
(Name of insurance company/attorney)

I, the undersigned, do hereby irrevocably assign, set over and grant a perfected security interest pursuant to the provisions of SDCL 57A-9 TO Dr. Shannon DeBoer DBA Cascade Chiropractic in and to any and all health-care insurance receivables due the undersigned as a result of health-care services provided me by the above named doctor or clinic by reason of accident, illness or any other health related condition. This is an irrevocable assignment of my rights and benefits to any monies owed or received for my benefit in the amount equal to any outstanding balance owed by me to the above named doctor or clinic.

In the event my insurance company or any other party obligated to make payments to me refuses to make payment upon demand by me or the above named doctor or clinic, I hereby assign and transfer to said doctor or clinic any and all causes of action I may have now or in the future against said party and do hereby authorize said doctor or clinic to prosecute said cause of action in my name or the name of said doctor or clinic and to compromise, settle or otherwise resolve such claim or cause of action.

I understand that I remain personally liable for all amounts due said doctor or clinic and that this Assignment and Authorization does not constitute consideration for said doctor or clinic to await payment and that the same may demand payment immediately upon rendering service and may charge interest at 15% per annum (compounded daily) on all balances after 30 days. If said doctor or clinic must take any collection action, I will be liable for all costs of collections actions, including court costs and reasonable attorney fees.

I authorize the above named doctor or clinic to release any records or information regarding my treatment to any insurance company, third party payor or attorney to facilitate collection of all benefits due me under this Assignment and Authorization and further authorize them to endorse on my behalf all checks and drafts issued to me, in my name or for my benefit.

This Assignment and Authorization shall be binding upon my legal heirs, personal representative(s), successors and assigns and any other person legally acting on my behalf.

Patient/Parent Signature _____________________ SS#_____-___-_______ Date:___________

Witness:____ Date: _______________