WEST-LAND CLINIC OF CHIROPRACTIC

1929 Dailey Avenue
Latrobe, PA 15650
Phone: 724-532-3077 Fax: 724-532-3155

Patient Name: _____

Date of Accident: _____

Attorney's Name: _____

Insurance/Adjustor Name: _____

Medical Claim #: _____

I hereby authorize West-Land Clinic of Chiropractic to furnish you with my complete medical records and a full report concerning case history, examination, diagnosis, treatment, and prognosis with regard to treatment related to the above-referenced accident.

I hereby irrevocably authorize and direct you, to pay directly to West-Land Clinic of Chiropractic, such sums as may be due and owing for medical services rendered to me by reason of the above referenced accident, and to withhold such sums from any settlement, judgment, award, or verdicts as may be necessary to fully and completely compensate West-Land Clinic of Chiropractic.

I hereby give a lien on my claim arising out of the above-referenced accident to said facility against any and all proceeds of any settlement, claim, judgment, or verdict for any outstanding balances owed at the time of distribution of funds from any settlement, claim, judgment, or verdict arising out of the above-referenced accident.

I fully understand that I am directly responsible to West-Land Clinic of Chiropractic for all medical bills submitted by them for services rendered to me and that this agreement is solely for West-Land Clinic's additional protection and in consideration of their awaiting payment.

I further understand that such payment is not contingent on any settlement, judgment, award, or verdict by which I may eventually recover.

_____ _____ _____

Patient/Legal Guardian Printed Name | Patient/Legal Guardian Signature | Date

****FOR OFFICE USE ONLY** (YOUR ATTORNEY WILL COMPLETE THE REMAINDER OF THIS FORM)**

The undersigned representative agrees to observe all terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect the above named provider and to issue such sums withheld to the above named provider directly.

_____ _____ _____

Attorney's Name | Attorney's Signature | Date

DOCTOR'S LIEN

Auto Intake

Patient Name_____Date_____

AUTO ACCIDENT INFORMATION

Date and time of accident:_____ __a.m. __p.m.

Were you the: __Driver __Front Passenger __Rear Passenger

Make and Model of the vehicle you were occupying?_____

If a traffic violation was issued,to whom was it issued?_____

Number of people in accident vehicle?_____

Did the police come to the accident site? __Yes __No

Was a police report filed? __Yes __No

Were there any witnesses? __Yes __No

Was this vehicle equipped with airbags? __Yes __No

If yes, did it/they deflate? __Yes __No

In relation to the base of the skull, where was the headrest? _Above _Below _At base of skull

What did your vehicle impact? __Another vehicle __Other
If other,explain:_____

Did any part of your body strike anything in the vehicle? __Yes __No
If yes, please describe:_____

Make and Model of the other vehicle(s) involved?_____

Name and location/street on which you were traveling?_____

In which direction were you headed? __N __S __E __W

What was the approximate speed of your vehicle?_____

Did the impact to your vehicle come from the: __Front __Rear __Rt Side __Lf Side __Other

During the impact were you facing: __Right __Left __Forward

Were you __aware or __suprised by the impact?

If the accident vehicle made impact with another vehicle...

Direction other vehicle was headed? __N __S __E __W

Approximate speed of the other vehicle?_____

In your words, please describe the accident:

_____

_____

Patient Name_____Date_____

AFTER INJURY

Did accident render you unconscious? __Yes __No

If yes, for how long?_____

Please describe how you felt immediately after the accident_____

Have you gone to a hospital or seen any other Doctor? __Yes __No

When did you go? __Just after accident __The next day __2 days plus

How did you get there? __Ambulance __Private transportation

Name of hospital and/or attending doctor:_____

Was he/she a: __D.C. __M.D. __D.O. __D.D.S.

Describe any treatment you received:_____
Were X-Rays taken? __Yes __No

Was medication prescribed? __Yes __No

Have you been able to work since this injury? __Yes __No

Are your work activities restricted as a result of this injury? __Yes __No

Indicate the symptoms that are a result of this accident:

__Dizziness __Difficulty sleeping __Jaw problems __Nausea

__Irritability __Arms/Shoulder pain __Back Pain __Headache(s)

__Numb hands/fingers __Lower back pain __Blurred vision __Tension

__Buzzing in ears __Neck pain __Chest pain __Leg pain __Ears ringing

__Neck stiff __Shortness of breath __Numb feet/toes __Stomach upset

__Memory loss __Fatigue __Back stiffness

__Other_____

Is condition getting worse? __Yes __No __Constant __Comes and goes

Patient Name_____Date_____

Indicate your degree of comfort while performing these activities:

	Comfortable	Uncomfortable	Painful
Lying on back.....	__	__	__
Lying of side.....	__	__	__
Lying on stomach.....	__	__	__
Sitting.....	__	__	__
Standing.....	__	__	__
Stretching.....	__	__	__
Lovemaking.....	__	__	__
Walking.....	__	__	__
Running.....	__	__	__
Sports.....	__	__	__
Working.....	__	__	__
Lifting.....	__	__	__
Bending.....	__	__	__
Kneeling.....	__	__	__
Pulling.....	__	__	__
Reaching.....	__	__	__

Have you retained an attorney? __Yes __No
If yes, whom?_____
His/Her phone#:_____

Recovery

How many hours are in your normal workday?_____

Please indicate on your daily job duties & activities, which you are occasionally asked to perform.

__Standing __Driving __Operating equipment __Stooping

__Sitting __Twisting __Work with arms above head

__Walking __Crawling __Lifting __Bending __Typing

Patient Name_____Date_____

What postions can you work in with minimum effort & for how long?

_____ __NA

Prior to the injury were you capable of working on an equal basis with others your age? __Yes __No

Do you work with others who can help you with any heavy lifting? __Yes __No

While in recovery, is there any light duty work? __Yes __NO

We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agencies, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date____/_____/_____

__Adult patient __Parent or Gaurdian __Spouse