MEIER
FAMILY CHIROPRACTIC

AUTO ACCIDENT HISTORY FORM

PATIENT'S NAME: _____

TODAY'S DATE: _____ **DATE OF INJURY:** _____

YOU'RE VEHICLE (YEAR, MAKE, MODEL): _____

YOU WERE:

- ☐ DRIVER
- ☐ FRONT SEAT PASSENGER
- ☐ REAR SEAT PASSENGER
- ☐ MOTORCYCLE OPERATOR
- ☐ MOTORCYCLE PASSENGER
- ☐ OTHER

ESTIMATED PROPERTY DAMAGE TO YOUR VEHICLE: $ _____

OTHER VEHICLE: (YEAR, MAKE, MODEL) _____

ESTIMATED DAMAGE TO OTHER VEHICLE: $ _____

TIME OF DAY: _____ DAYLIGHT _____ DAWN _____ DUSK _____ DARK

ROAD CONDITIONS:_____ DRY _____ DAMP _____ WET _____ SNOW _____ ICE _____ OTHER

YOUR ESTIMATED SPEED AT MOMENT OF CRASH:

- ☐ STOPPED
- ☐ SLOWING _____
- ☐ ACCELERATING _____

WERE YOU WEARING A SEAT BELT?

- ☐ YES
- ☐ NO

DID THE AIR BAG DEPLOY?

- ☐ YES
- ☐ NO

IF YES, WERE YOU STRUCK?

- ☐ YES
- ☐ NO

CRASH DESCRIPTION:

_____
_____
_____
_____
_____

POLICE ON SCENE:

- ☐ YES
- ☐ NO

REPORT MADE:

- ☐ YES
- ☐ NO

WHERE DID YOU GO AFTER THE CRASH:

- ☐ HOME
- ☐ WORK
- ☐ HOSPITAL

IF ADMITTED TO THE HOSPITAL WERE THERE ANY X RAYS TAKEN, OR DIAGNOSIS MADE?

_____

_____

ARE YOU UNDERGOING ANY TREATMENT FROM RESULTS OF THE ACCIDENT?

_____

_____

CURRENT HEALTH PROBLEMS:

_____

_____

CURRENT MEDICATIONS:

_____

_____

PAST MEDICAL HISTORY:

_____

_____

SURGERIES:

_____

_____

FRACTURES:

_____

_____

SERIOUS ILLNESS/ PERSONAL INJURIES:

_____

_____

INSURANCE COMPANY THAT WE WILL BE BILLING:

SUBSCRIBER NAME: _____
INSURANCE COMPANY NAME: _____
ADDRESS TO SUBMIT CLAIMS: _____
CITY, STATE, ZIP: _____
NAME OF ADJUSTER HANDLING YOUR CLAIM: _____
ADJUSTER'S DIRECT PHONE & EXTENSION: _____
CLAIM NUMBER: _____

3RD PARTY MEDICAL LIEN & ASSIGNMENT

Patient:
Claim #:
Date of Injury: State of Accident or Injury:

I hereby authorize and direct _____ Insurance Company, to pay to Meier Family Chiropractic such sums as may be due and owing him/her for services rendered me by reason of the accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. I hereby further request and instruct you that payments be made as claims are received, as per Ridley, and that payments be made directly to said doctor which would otherwise be paid to myself, as the result of the treatment charges incurred for injuries in connection therewith. This is a direct assignment of my rights and benefits under this claim.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him/her for services rendered me and that this agreement is made solely for said doctor's protection and in consideration of his/her waiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover.

Please acknowledge your agreement to this request by signing below and returning to the doctor's office below. I have been advised that if you do not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable by me.

_____ _____
Date Patient's Signature

The undersigned insurance company does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect and fully compensate said doctor above and below named and make payment payable directly to said doctor.
Balance Due: _____ as of _____.

_____ _____
Date Signature of Insurance Company Representative

_____
Print First and Last Name

_____
Insurance Company Name

Please date, sign and return one copy to the doctor's office below.

Meier Family Chiropractic

3419 Central Ave Suite C

Billings, MT 59102

PATIENT RECORDS AND DOCTOR'S LIEN

TO: ATTORNEY/INSURANCE CARRIER

_____ Patient Name:_____

_____ Claim #_____

_____

_____

I do hereby authorize the above provider to furnish you, my attorney/insurance carrier, with a full report of his/her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness which occurred/began on:_____.

I hereby give a lien to said provider on any settlement, judgment or verdict as a result of said accident/illness and authorize and direct you, my attorney/insurance carrier, to pay directly to said provider such sums as may be due and owing him/her for services rendered me, and to withhold such sums from settlement, claim judgment or verdict as may be necessary to protect said provider adequately.

I fully understand that I am directly and fully responsible to said provider for all bills submitted by him/her for services rendered me, and that this agreement is made solely for said provider's additional protection and in consideration of his/her awaiting payment. I further understand that such payment is not contingent on any settlement, claim judgment or verdict by which I may eventually recover said fee.

I further agree to be fully responsible for reasonable attorney's fees and costs that have accrued due to the pursuance of payment of my account. Also, that in the event of noncompliance to payment agreement I understand the amount of balance due will be subject to a 1% per month service charge.

Patient Signature:_____ Date:_____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately the above named provider.
Balance due:_____as of _____. Please call for final balance before settlement.

Attorney's Signature:_____ Date:_____

Please sign, retain a copy for your records, and return this copy to us promptly.

Meier Family Chiropractic

3419 Central Ave Suite C

Billings, MT 59102