Mike Fleming, B.Sc., D.C.
Ben Cain, D.C., C.C.S.P., C.S.C.S.

Active Health Solutions

O'Malley Professional Centre
1000 O'Malley Road, Suite 102
Anchorage, Alaska 99515

OFFICE (907) 349-5552 | Chiropractic, Active Release Technique, Sports Therapy | FAX (907) 349-5100

FINANCIAL POLICY:
AUTOMOBILE/PERSONAL INJURY

1. Our office will accept your insurance assignment, along with a signed Doctor's Lien and Notice to Insurance Company/Acknowledgement of Insurance Company. This is a courtesy we offer to our patients.

2. When no insurance companies are involved other than a third party (someone else was at fault), or this claim goes to trial, we will accept a Doctor's Lien and an Acknowledgement of Assignment on your behalf.

These agreements are valid with this office for one (1) year from the original date of treatment. At the end of one year, if this claim is not settled, you, the patient, are responsible for payment. Personal injury claims are not carried for longer than one (1) year unless prior authorization has been obtained from the doctor.

3. If you have either personal or automobile insurance we will file this claim under one of these policies. At the time your claim is settled, the two insurance carriers may settle up between themselves.

4. This policy is valid only during your actual treatment at our clinic. If you discontinue care without the doctor's prior authorization, the balance of your account will become due and payable in full.

5. If you understand and agree with all of the above office policies, please sign and date.

_____ _____

PATIENT'S SIGNATURE DATE

_____ _____

WITNESS' SIGNATURE DATE

ART

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DOCTOR'S LIEN

To: Insurance Carrier / Attorney

_____
_____
_____
_____

Doctor:_____

RE: Patient Records and Doctor's Lien

I do hereby authorize the above doctor to furnish you, my insurance carrier/attorney, with information regarding my history, examination, diagnosis, treatment and prognosis of myself with regard to my accident/injury which occurred/began on date:_____.

I do hereby give a lien to the above mentioned doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my insurance carrier/attorney, to pay directly to said doctor such sums as may be due and owing for services rendered me.

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

Dated:_____ Patient's Signature: _____

ACKNOWLEDGEMENT OF DOCTOR'S LIEN

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient, does acknowledge receipt of the above lien, and does agree to honor the same to protect said above named doctor.

Dated:_____ Authorized Signature: _____

**** Please date, sign and fax back to us at (907)349-5100. Keep a copy for your records.***

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NOTICE TO INSURANCE COMPANY OF ASSIGNMENT

To: _____

_____

_____

You are instructed to pay direct to the doctor at his/her office for all professional services rendered to me.

This instruction to you is an ASSIGNMENT OF RIGHTS under my medical coverage to the extent of this bill.

Any sum of money paid under this assignment shall be credited to my account and I shall be personally liable for any unpaid balance.

Pay to doctor: _____

_____

PATIENT'S SIGNATURE & DATE

_____

PATIENT'S NAME

_____

PATIENT'S ADDRESS

_____

ACKNOWLEDGEMENT OF INSURANCE COMPANY

This insurance company hereby acknowledges receipt of the above ASSIGNMENT OF BENEFITS and agrees to forward payment of medical services rendered. Payment will be sent to the office of and to the order of the doctor only.

Authorized Signature: _____ **Date:** _____

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PERSONAL INJURY –DATA FORM **Patient Name:**_____

Date of accident:_____ Time of accident:_____ □AM □PM

Number of people involved:_____ Number of cars involved: _____

Location of accident (address if possible):_____

Closest bisecting street/town:_____

Driver of car:_____ Where were you seated?_____

Who owns the car?_____ Year/model of car:_____

What was the approximate damage done to your car?_____

Visibility at time of accident: □Poor □Fair □Good □Other:_____

Road conditions at the time of accident: □Icy □Rainy/ wet □Clear □Dark Other:_____

(Describe):_____

Where was the car struck? □Right □Left □Rear □Front □Side □Car rolled □Other:_____

Type of accident: □Head-on collision □Broad-side collision

□Rear-end collision □Front impact, rear-ended car in front

□Non-collision (describe):_____

Describe in your own words what happened to you upon impact:_____

_____

_____

Did you see the accident coming? □Yes □No

Did you brace for impact? □Yes □No

Were seat belts worn? □Yes □No

Were shoulder harnesses worn? □Yes □No

Does your car have headrests? □Yes □No

If yes, what was the position of those headrests compared to your head before the accident?

□Top of headrest even with bottom of head.

□Top of headrest even with top of head.

□Top of headrest even with middle of neck.

Was the car braking? □Yes □No

Was your car moving at the time of the accident? □Yes □No

If yes, estimate how fast you were going? _____mph

Estimate how fast the other car was traveling:_____mph

Were you wearing glasses? □Yes □No If yes, did they come off in the accident? □Yes □No

Body position at the time of impact:

□Head turned left/right □Body straight in sitting position

□Looking back □Body rotated left/right

□Head straight □Other:_____

At the time of the accident, recall what parts of your head or body hit what parts of the inside of your car:

_____

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Upon impact, was there a blinding or explosive sensation in your head? □Yes □No

As a result of the accident were you:

□Rendered unconscious □Dazed/circumstances vague □Other:_____

Could you move all parts of your body? □Yes □No If no, describe:_____

_____

Were you able to get out of the car and walk unaided? □Yes □No If no, why not?_____

_____

Please describe how you felt immediately after the accident. Be specific. _____

_____

What bleeding cuts did you get from the accident?_____

What bruises did you get from the accident?_____

When did these appear? □Later that day/night □The next day/night

Check symptoms apparent <u>since</u> the accident:

□Headache	□Loss of smell	□Numbness in fingers
□Neck pain/stiffness	□Loss of taste	□Cold hands
□Mid back pain	□Loss of memory	□Cold feet
□Low back pain	□Fatigue	□Diarrhea
□Eyes sensitive to light	□Tension	□Constipation
□Pain behind eyes	□Shortness of breath	□Chest pain
□Dizziness	□Irritability	□Nervousness
□Fainting	□Depression	□Cold sweats
□Ringer/buzzing in ears	□Sleeping problems	□Anxious
□Loss of balance	□Numbness in toes	□Other:_____

Occupation:_____ Employer:_____

Have you missed time from work? □Yes □No

If yes,

Full time off work_____to_____.

Part time off work_____to_____.

□ Have been unable to work since the accident.

Did you go to seek medical help? □Yes □No If yes, when?_____

If yes, how did you get there? □Someone else drove my car □Ambulance

□Drove my own car □Police

□Other:_____

1st Doctor seen:_____ Hospital/Clinic:_____ Date:_____

Were you examined? □Yes □No Were x-rays taken? □Yes □No

What treatment was given to you? □Bed rest □Brace □Physiotherapy □Adjustments □Other:_____

_____ ART

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Were you prescribed any drugs or medication? □Yes □No Other:_____
Did you take them? □Yes □No Were they effective? □Yes □No
Date of last treatment with this doctor:_____

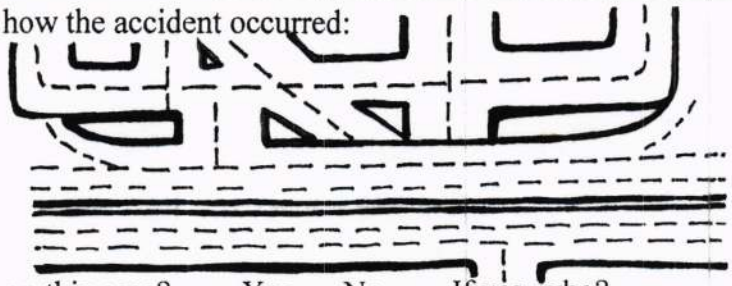
2nd Doctor seen:_____ Hospital/Clinic:_____ Date:_____
Were you examined? □Yes □No Were x-rays taken? □Yes □No
What treatment was given to you? □Bed rest □Brace □Physiotherapy □Adjustments □Other:_____
_____
Were you prescribed any drugs or medication? □Yes □No Other:_____
Did you take them? □Yes □No Were they effective? □Yes □No
Date of last treatment with this doctor:_____

Did you have any physical complaints before the accident? □Yes □No
If yes, please describe in detail:_____
_____
_____

Prior to this accident, have you ever had symptoms similar to what you experiences now? □Yes □No
If yes, please explain (briefly include pat falls, injuries, accidents, operations, etc):_____
_____
_____

Do you notice any activities of your daily routines that are different now than from before the accident?
□Yes □No If yes, list them as:
Activities that you are unable to do: _____
Activities that are painful to do: _____
Activities that are difficult to do: _____

Indicate on this diagram how the accident occurred:



Do you have an attorney on this case? □Yes □No If yes, who?_____
Their address/phone:_____

Patient's signature:_____ Date:_____

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AUTOMOBILE ACCIDENT INSURANCE INFORMATION

Your Insurance Information:

Company name:_____ Phone:_____
Insured's name, if other than patient:_____
Claim or policy number (indicate which):_____
If assigned an adjuster for this claim, their name:_____ Phone:_____
Billing address for this claim:_____
_____
Does this company hold the primary responsibility for this claim? □Yes □No

Other Driver's Insurance Information (if another car was involved)

Driver's Name:_____
Company name:_____ Phone:_____
Claim or policy number (indicate which):_____
If assigned an adjuster for this claim, their name:_____ Phone:_____
Billing address for this claim:_____
_____
Does this company hold the primary responsibility for this claim? □Yes □No

Please describe insurance coverage below if multiple parties are involved:

_____
_____
_____
_____
_____
_____