PERSONAL INJURY FORM

THIS FORM MUST BE FILLED OUT
COMPLETELY BEFORE TREATMENT STARTS

INSURANCE COMPANY OR LAW FIRM NAME: ______________________

CLAIM OR CASE NUMBER: ______________________

ADJUSTER OR LAWYER NAME: ______________________

PHONE NUMBER: ______________ EXT: ________

FAX NUMBER: ______________________

NOTICE: Having insurance information is not a guarantee that they will cover your fees in full. Whatever your insurance provider does not pay will be your responsibility. If you fail to keep in contact with the insurance company and your case closes before our bill is paid in full, you will be responsible for your balance.

AUTO ACCIDENT REPORT FORM

Patient Name: ______________________________ **Time of Incident:** ______ ☐ a.m ☐ p.m

Date of Accident: ______________ **City of Accident:** ______________________________

Street of Accident: ______________ **Cross Street** (Intersection): ______________

Road conditions at the time of the incident: ☐ Wet ☐ Dry ☐ Icy ☐ Other ______________

Did the police come to the scene of the accident? ☐ Yes ☐ No

Was an accident report filed? ☐ Yes ☐ No

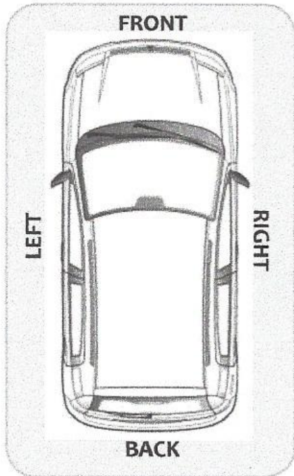
Were you taken to a hospital? ☐ Yes ☐ No

Hospital Name & City: ______________________________

How did you get to the hospital? ______________________________

Were X-Rays taken? ☐ Yes ☐ No If yes, what was X-Rayed? ☐ Head ☐ Neck ☐ Upper Back ☐ Mid-Back ☐ Lower Back ☐ Other: ______________

Indicate where the initial impact struck your vehicle by marking an "X" on the diagram below:



The following questions pertain to you, the patient, and the vehicle you were in:

Were you seated in the vehicle? ☐ Yes ☐ No

Were you aware of the approaching collision, or did the impact catch you by surprise? ☐ Aware ☐ Surprise

Did you lose consciousness (black out) upon impact? ☐ Yes ☐ No If yes, for how long? ______________

How far is the top of the headrest/seatback from the top of your head? Approximately: ____ inches ☐ Above ☐ Below

Were you wearing a seatbelt? ☐ Yes ☐ No If yes, what type? ☐ Lap Belt ☐ Shoulder Belt

Vehicle Information & Velocity:

Vehicle Year: ________ Make: ______________ Model: ______________

Was your car moving, or stopped? ☐ Moving ☐ Stopped

If your car was moving:

How fast were you going? Approximately _____ m.p.h

Just before impact, the car was: ☐ Slowing Down ☐ Speeding Up ☐ Constant Speed

Please explain the details of the accident to the best of your knowledge:

Were there bleeding cuts caused by the accident? ☐ Yes ☐ No Where: ______________________

Did the accident cause any bruises? ☐ Yes ☐ No Where: ______________________

Where did the following body parts hit during the accident:

Head: ______________________

Chest: ______________________

R/L Shouder: ______________________

R/L Arm: ______________________

R/L Hip: ______________________

R/L Leg: ______________________

R/L Knee: ______________________

Other: ______________________

What was the cost of damage to the vehicle you were in? $______________

Which (if any) of the following car parts broke during the accident:

☐ Windshield ☐ Steering Wheel ☐ Front Seat ☐ Back Seat ☐ Side Window (R/L) ☐ Other: ____________

Was the trunk of your body pointed straight forward at the time of impact? ☐ Yes ☐ No

If No, which direction was it pointed, and by how much? ______________________

Was your head pointed straight forward at the time of impact? ☐ Yes ☐ No

If No, which direction was it turned, and by how much? ______________________

The following questions pertain to the other vehicle involved in the accident:

Other Vehicle Year: ________ Make: ______________ Model: ______________

Was the other car moving, or stopped? ☐ Moving ☐ Stopped

If the other car was moving:

How fast was it going? Approximately _____ m.p.h

Just before impact, the other car was: ☐ Slowing Down ☐ Speeding Up ☐ Constant Speed

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If you have been involved in previous auto accidents, please list the year of each incident:

Please list any additional information not covered above that we should know about:

____

Signature of Patient

____

Patient Name (Printed)

Date ____ / ____ / dude

Covington Family Chiropractic
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NOTICE OF DOCTOR'S LIEN

I hereby authorize and instruct my attorney, ______________________________ to pay **Covington Family Chiropractic** directly for the full amount of services rendered by **Covington Family Chiropractic** in relation to my personal injury treatment arising from my accident on or about ____________ once a settlement or verdict is reached and those funds are made available or disbursed.

I understand that I am directly and fully responsible for all medical bills incurred at **Covington Family Chiropractic** for services rendered to me with respect to any personal injury treatment. Further, I understand that I am responsible for the payment of all services rendered by **Covington Family Chiropractic** regardless of whether or not I receive any proceeds from any insurance company or third party, and that my obligation and liability to **Covington Family Chiropractic** is in no way conditioned upon any settlement of verdict.

I agree to promptly notify **Covington Family Chiropractic** of any changes in my representation or attorney for this accident.

By signing below I acknowledge and agree to this lien in favor of **Covington Family Chiropractic** the full amount owed for any and all services rendered to me by Covington Family Chiropractic.

I acknowledge that **Covington Family Chiropractic** is not required to permit me the option to postpone or make payments toward of services rendered, and that it is being done solely as a courtesy. As such, **Covington Family Chiropractic** may, at any time, seek payment for any and all amounts owed by me while this lien is in force. Additionally, if my attorney fails to acknowledge this lien in favor of **Covington Family Chiropractic**, the entire balance related to this personal injury treatment is my sole responsibility, and **Covington Family Chiropractic** may demand payment immediately.

______________________________ Print Practice Members Name

______________________________ Practice Member Signature

______________________________ Date

Acknowledged by Attorney this __________day of __________________, 20_________

______________________________ Attorney Signature