VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Patient Name_____ Date _____

Date of Accident _____ Time of Accident _____ ☐ am ☐ pm

Please describe the accident in your own words _____

_____

_____

_____

Were you the ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle _____

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest Intersection with road/street _____

Driving Conditions:

☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed _____

Speed you were traveling _____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, was the position of the headrest

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle _____

Did your car impact a structure _____

If yes explain _____

_____

Did any part of your body strike anything in the vehicle?

If yes explain _____

_____

Was impact from: ☐ Front ☐ Rear ☐ Left ☐ Right

Other: _____

At the time of impact were you:

☐ looking straight ahead ☐ Looking to the Right

☐ Looking to the left ☐ Looking Down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you ☐ Surprised by the impact ☐ Braced for impact

OTHER VEHICLE

(if applicable)

Make and model of other vehicle_____

Which direction was the other vehicle headed_____

Speed other vehicle was traveling _____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom? _____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long? _____
Please describe how you felt immediately after the accident _____
_____
_____
_____

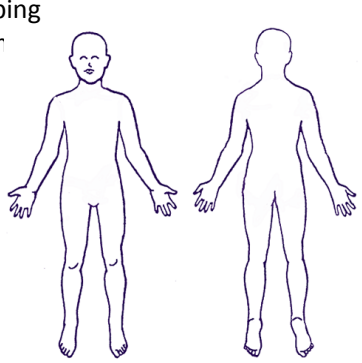
TREATMENT

Did you go to the hospital? ☐ Yes ☐ No
When did you go? ☐ Immediately after the accident ☐ Next day ☐ 2 days or more after the accident
How did you get to the hospital? ☐ Ambulance ☐ Private transportation
Name of hospital _____ Name of Doctor _____
Diagnosis _____
_____
Treatment received _____
_____
X-rays taken _____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed: _____
Prior to the injury, were you able to work on an equal basis with others you age? ☐ Yes ☐ No
If you have had any of the following symptoms since your injury please check all that apply:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiff
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Difficulty sleeping
☐ Dizziness	☐ Jaw problems	☐ Upset stomach
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Blurred vision
☐ Fatigue	☐ Nausea	



Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness or tingling

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain:	☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
	☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
	☐ Cramping	☐ Stiffness	☐ Swelling	☐ Other _____

How often do you have this pain? _____
Is it constant or does it come and go? _____
Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Activities or movements that are painful to preform: ☐ Sitting ☐ Standing ☐ Walking
☐ Bending ☐ Lying Down

I certify that the above information is correct to the best of my knowledge

Patient Signature _____ Date _____

ASSIGNMENT OF BENEFITS

In CONSIDERATION of the willingness of Zimmerman Family Wellness to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to Zimmerman Family Wellness any proceeds or compensation that I am or may become entitled to receive as a result of the injuries that occurred on _____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to Zimmerman Family Wellness from any disability benefits, medical payment benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums are due or may become due to Zimmerman Family Wellness for its services rendered.

I appoint Zimmerman Family Wellness as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Zimmerman Family Wellness.

I authorize Zimmerman Family Wellness to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain liable for the total amount due to Zimmerman Family Wellness for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If Zimmerman Family Wellness is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Zimmerman Family Wellness for its costs of recovery, including reasonable attorney's fees.

_____
Patient Signature (Guardian if Minor)

_____
Date

_____
Witness

NOTICE OF LIEN

Pursuant to N.C.G.S § 44-49 and 44-50, Zimmerman Family Wellness hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

Zimmerman Family Wellness hereby requests that is its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S § 44-50.1 Zimmerman Family Wellness agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

Zimmerman Family Wellness

By _____

MEDPAY INFORMATION

A lot of people have medical benefits ("medpay") included on their insurance policies, and don't even realize it. Our office highly recommends that you use your medpay coverage, if you have it, in the event that you have been injured in an automobile accident, regardless of who was at fault.

Here are 3 major reasons that we file your medpay:

1. MEDPAY IS EXACTLY LIKE HEALTH INSURANCE - USING IT DOESN'T CAUSE YOUR RATES TO INCREASE. If your rates increase, it's not because you filed your medpay, it's most likely because: (a) It was determined that you were at fault, (b) you received the police citation or ticket, or (c) you've been involved in numerous reported auto accidents within a brief period of time, and therefore are now considered to be "high risk."

2. FILING YOUR MEDPAY DOES NOT RELIEVE THE OTHER PARTY FROM HAVING TO PAY IN FULL FOR YOUR LOSS. On the contrary, by filing your medpay, when you collect from the other driver's liability insurance, a greater amount of the settlement will go directly to you because your bill at our office will be less or even paid in full. If the other driver's liability insurance refuses to make payment for whatever reason, filing your medpay will help to insure that you are not stuck with all the medical bills.

3. IF YOU HAVE MEDPAY COVERAGE AND CHOOSE NOT TO FILE IT, THEN YOU ARE PAYING FOR AN OPTION, BUT NOT RECEIVING ANY BENEFIT. For the very same reasons, our office recommends that you pay your commercial health insurance. The important thing to remember is that you are not guaranteed of receiving full payment from the liable party's insurance. Filing both your medpay and health insurance will help insure that you are not left to pay the medical bills.

OUR OFFICE FINANCIAL POLICY

As long as our office filing your medpay and health insurance, and these companies are continuing to cover your charges, we will waive collection of payment at the time of service. If we receive overpayment on your account, we will be happy to refund you the difference. Any balance owing will become immediately due and payable should your case not settle within a reasonable time from your release from care.

*Zimmerman Family Wellness reserves the right to deduct $150.00 for filing your Medpay claim. Applicable only if collected.

I am filing medpay for treatment received to Zimmerman Family Wellness and I understand that if the liable party does not pay my bill in full, I will be responsible for the balance in full.

This agreement is made solely for Dr. Zimmerman's protection and in consideration of their awaiting payment.

Patient Signature _____ Date _____

Parent /Guardian Signature _____ Date _____

Witness _____Date _____