SLIP AND FALL INJURY HISTORY

NAME: _____ ADDRESS: _____

AGE: _____ Date Of Birth: _____ Sex: F ( ) M ( )

Date of Injury:_____ Time:_____ AM / PM

State how the accident happened: _____

_____

Did you seek medical attention after the accident?_____

Were you hospitalized? ____ If yes, where and for how long? _____

Did you receive care from any other health care specialist? _____

If yes, who and how long? _____

Did you miss any work due to the injury? Yes ( ) No ( ) If yes, what days?

_____

At the time of the accident where did you feel pain?

_____

_____

What are your current symptoms? _____

_____

Have you ever been injured in a similar manner? _____ If yes, how and when?_____

PARTY REPSONSIBLE

Did you report the injury? _____ To whom?_____

Please fill in the following information on the party responsible:

NAME: _____ ADDRESS:_____

PHONE #: _____ CONTACT : _____

INSURANCE CO: _____ ADDRESS: _____

PHONE #: _____ ADJUSTER: _____

CLAIM#: _____ POLICY#: _____

ATTORNEY INFORMATION (IF APPLICABLE)

ATTORNEY: _____ PHONE#: _____

ADDRESS: _____

BILLERICA CHIROPRACTIC OFFICE, P.C.
25 BRIDGE STREET BILLERICA, MA 01821
(978) 667-1932
www.billericachiro.com

ASSIGNMENT, LIEN, AUTHORIZATION AND POWER OF ATTORNEY

I hereby authorize and direct, _____, my insurance company and/or _____, my attorney, to pay directly to Billerica Chiropractic Office, P.C. (Chiro), such sums as may be due and owing to Chiro for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from an disability, no-fault, health, accident, worker compensation or any other benefits, or from any settlement, judgment or verdict which may be paid to me as a result of the injuries of illness for which I have been treated by Chiro. This is an irrevocable assignment of my rights and benefits to the extent of Chiro's services provided.

In the event any insurance company is obligated to make payments to me upon the charges made by Chiro for their services, and refuses to make payment to said Chiro, upon demand by me or Chiro, I hereby assign and transfer to Chiro any and all causes of action that I have or that might exist in my favor, against such company, and I authorize Chiro to prosecute such cause(s) of action either in my name or their name, and further, I authorize Chiro to compromise, settle or otherwise resolve said claim or cause(s) of action.

I understand that I remain personally responsible for the total amounts due to Chiro for their services. I further understand and agree that nothing herein constitutes consideration for Chiro to await payments and they may demand payments for or from me immediately upon rendering services. I hereby grant to Chiro, my Power of Attorney for the sole purpose of endorsing any negotiable instrument payable to it, its employees and/or me for services by it and/or its employees. I further grant Chiro my Power of Attorney for the purpose of signing on my behalf any insurance form, PIP form, authorization, or major medical insurance form necessary and/or settlement drafts to collect my insurance benefits.

In the event that any of the provisions contained herein are unenforceable, for any reason whatsoever, all remaining provisions shall be in full force and effect.

I authorize Chiro to request and/or release any information pertinent to my case to any insurance company, adjuster, attorney or my employer to facilitate collection under this Agreement, Lien and Authorization.

I hereby state that a photocopy of this document will be deemed as valid and binding on all parties as the original.

_____	_____	_____
Signature	Print Name	Date
_____	_____	_____
Witness	Print Name	Date

Authorization for Release of Records & Physician's Lien

TO: ATTORNEY/INSURANCE CARRIER

_____

_____

_____

FROM: Billerica Chiropractic Office, P.C.
25 Bridge Street
Billerica, MA 01821
(978) 667-1932
www.billericachiro.com

RE: PATIENT RECORDS AND DOCTOR'S LIEN

Ref Patient Name: _____ DOB: _____

RELEASE OF RECORDS: I do hereby authorize Billerica Chiropractic Office to furnish you, my attorney/insurance carrier, with a full report of the doctor's case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident /illness which occurred/began on _____ (date of accident or injury).

LIEN ON SETTLEMENT: I hereby give a Lien to Billerica Chiropractic Office on any settlement, claim, judgment, or verdict as a result of said accident / illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to Billerica Chiropractic Office such sums as may be due and owing my doctor for service rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect Billerica Chiropractic Office adequately.

IRREVOCABLE LIEN: I understand that this Lien shall be irrevocable either by myself or any other agent that represents me; that in the event another attorney is substituted in this matter, the new attorney shall honor this lien as inherent to the settlement and enforceable upon the case as if it was executed by him.

RESPONSIBILITY FOR PAYMENT: I fully understand that I am directly and fully responsible to Billerica Chiropractic Office for all chiropractic bills submitted by the doctor for service rendered me, and that this agreement is made solely for Billerica Chiropractic Office's additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

A photocopy or facsimile of this executed instrument shall be considered as valid as the original.

Patient Signature: _____ Dated: _____

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 Billerica Chiropractic and to withhold such sums from any settlement, judgment or verdict, after subtraction of attorney fees and expenses, as may be necessary to adequately protect the said provider and Billerica Chiropractic Office.

Auth. Signature: _____ Dated: _____

NOTICE: Please date, sign, and return the original to our office as soon as possible.
(Reply envelope attached)

Financial Responsibility for Personal Injuries

- **It is YOUR responsibility to provide accurate information concerning your injury within 3 days of starting care at this office. If this information is not provided, you will be presented with a bill, which must be paid in full at that time.**
- **We will file all the necessary paperwork to process this claim. Although, it is your responsibility to know where you stand at all times concerning this bill at Billerica Chiropractic.**
- **On a monthly basis you will receive a current statement to keep you informed of the services rendered at this office.**
- **Any payment for services that the company denies or refuses to cover will become your responsibility.**
- **It is very important that you follow your plan of care so that you do not jeopardize the validity of your injuries.**

I have read and understand this policy.

Patient signature: _____ **Date: _____**

Guardian signature: _____ Date: _____