Stine Chiropractic Clinic, P.C.

117 Redwood Drive Fredericksburg, VA 22408 (540) 898 -4100

Larry L. Stine, D.C., F.A.C.O

SPECIALIZING IN CHIROPRACTIC ORTHOPEDICS AND SPORTS INJURIES

PERSONAL INJURY

Patient Name: ____________________

Address: ____________________

City/State: ____________________

Date Injured: ____________________

Auto Insurance: ____________________

Address: ____________________

City/State: ____________________

Phone #: ____________________

Policy/Claim #: ____________________

3rd Party: ____________________

Address: ____________________

City/State: ____________________

Phone #: ____________________

Claim #: ____________________

Patient Signature: ____________________ **Date:** ____________

PERSONAL INJURY QUESTIONNAIRE

Name ______________________________ Phone (   ) ____________

Address ______________________ City ____________ State ________ Zip ________

Age ______ Birthdate ______________ Sex ______ S/S # ______________

Employer's Name ______________________ Employer's Address ______________________

Your Ins. Co. ____________ Policy # ____________ Agent's Name ____________

Name on Policy (If other than self) ______________________ Policy # ____________

Responsible Party's Name ______________________________

Address ______________________ City ____________ State ________ Zip ________

Policy Holder's Name ______________________________ Policy # ____________

ATTORNEY

Name ______________________________ Phone (   ) ____________

Address ______________________ City ____________ State ________ Zip ________

Were there any witnesses? ( ) Yes ( ) No Name(s) ______________________

NATURE OF ACCIDENT:

1. Date of Accident ____________ Time of Day ____________
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? ______ Were you wearing seat belts? ______________
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West

   on (name of street) ______________________________
5. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West

   on (name of street) ______________________________
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Approximate speed of your car ______ mph Other car ______ mph
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? ____________
9. Were police notified? ( ) Yes ( ) No
10. In your own words, please describe accident: ______________________________

    ____

    ____

    ____
11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe in detail:

    ____

    ____

    ____
12. Please describe how you felt:

    a. DURING the accident: ______________________________

    b. IMMEDIATELY AFTER the accident: ______________________________

    c. LATER THAT DAY: ______________________________

    d. THE NEXT DAY: ______________________________

13. What are your PRESENT complaints and symptoms? ______

______

14. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No If yes, please describe:

______

15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If yes, please describe:

______

16. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received. ______

______

17. Where were you taken after the accident? ______

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name and address: ______

What type of treatment did you receive? ______

______

19. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Irritablity	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ ______

Symptoms Other Than Above ______

21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete this question.

a. Last Day Worked: ______

b. Type of Employment: ______

c. Present Salary: ______

d. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving: ______

22. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe, in detail:

______

______

______

23. Other pertinent information: ______

______

______

______

______ DATE

______ PATIENT'S SIGNATURE

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SPECIALIZING IN CHIROPRACTIC ORTHOPEDICS AND SPORTS INJURIES

PERSONAL INJURY FACT SHEET

- It is highly recommended that you follow the prescribed treatment plan as closely as possible in order to maximize the benefits of chiropractic treatment and minimize the delay of payment of your care.

- Due to the length of time it may take to settle a personal injury claim, we ask our patients to set up a "good faith" payment arrangement which defers payment and keeps your account in good standing. See monthly payment arrangement contract.

- Stine Chiropractic Clinic (SCC) submits all personal injury claims to the patient's auto insurance, 3rd party payers, or health insurance carriers for services rendered. SCC reserves the right to refuse to release patient claims, itemized statements, or any other documentation utilized for the purpose of obtaining payment directly to the patient.

- Any payment made directly to the patient is due upon receipt of the payment. The billing department routinely verifies claim status; any balance not paid in full upon receipt of payment will be turned over to collections within 10 days of discovery. See Collections Contract.

- Our charges are within the 50th percentile of usual and customary rates for our geographical area and any unpaid portion of the claim will become the patient's responsibility to pay out of pocket. We do not accept offers of discounts from any insurance carriers or attorneys on personal injury accounts.

I have read Stine Chiropractic Clinics Personal Injury Fact Sheet and accept the payment terms as described above. Any payment received by me from insurance carriers or attorneys for services rendered at SCC will be paid in full within 10 business days of receipt.

Name: ______________________________ Date: ________________________

(Please Print)

Signature: ____

IRREVOCABLE ASSIGNMENT, AUTHORIZATION AND LIEN

To Whom It May Concern:

With this Irrevocable Assignment, Authorization and Lien (this "Assignment"), and in consideration of treatment without having to render concurrent payment, I, the undersigned patient, hereby irrevocably transfer set over and assign to **STINE CHIROPRACTIC CLINIC, P.C.** all insurance and/or litigation proceeds to which I am now or may hereafter become entitled, including those listed below, up to the total amount due and owing **STINE CHIROPRACTIC CLINIC, P.C.** for services rendered to the undersigned by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due to **STINE CHIROPRACTIC CLINIC, P.C.** , including without limitation, requested reports, collection costs and expenses and attorneys' fees, and I further hereby irrevocably authorize and direct any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from me and pay directly **STINE CHIROPRACTIC CLINIC, P.C.** such amount(s) from (1) any insurance benefits payable to me or on my behalf, including, but not limited to medical payments benefits, No Fault benefits, health and accident benefits, foundation grants, governmental or agency benefits, worker's compensation benefits or an other insurance proceeds or benefits of any kind which are payable to or on behalf of the undersigned, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in my favor as may be necessary to fully pay any and all financial obligations owed to **STINE CHIROPRACTIC CLINIC, P.C.** by the undersigned. This Assignment is to be a complete and current transfer of my right, title and interest, separate from any statutory or contractual lien or claim to which **STINE CHIROPRACTIC CLINIC, P.C.** may also be entitled.

The undersigned patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to **STINE CHIROPRACTIC CLINIC, P.C.** fails or refuses to make payment for the full amount due as set forth above, this Assignment is to act as a full, immediate and complete assignment of all of the undersigned's rights, title, interest, remedies and benefits in and to the assigned property to the extent of **STINE CHIROPRACTIC CLINIC, P.C.** total claim amount; therefore, I hereby irrevocably assign and transfer to **STINE CHIROPRACTIC CLINIC, P.C.** any and all causes of action that I might have or that might exist in my favor against such insurance company and/or attorney and authorize, and nominate and appoint as my attorney-in-fact any officer, of **STINE CHIROPRACTIC CLINIC, P.C.** to prosecute said causes(s) of action either in my name or in **STINE CHIROPRACTIC CLINIC, P.C.** name and further I authorize **STINE CHIROPRACTIC CLINIC, P.C.** to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

I hereby further give a lien to **STINE CHIROPRACTIC CLINIC, P.C.** against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the undersigned as a result of the injuries or illness for which I have been treated by **STINE CHIROPRACTIC CLINIC, P.C.** The undersigned patient further agrees that **STINE CHIROPRACTIC CLINIC, P.C.** statute of limitations on its right to demand payment from the undersigned patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the undersigned patient are ongoing.

Notwithstanding the foregoing, the undersigned patient agrees that until **STINE CHIROPRACTIC CLINIC, P.C.** is paid in full, the undersigned shall remain personally and fully responsible for and promises to pay the total amount due to **STINE CHIROPRACTIC CLINIC, P.C.** (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The undersigned further understands and agrees that this Assignment does not constitute any agreement of or consideration for **STINE CHIROPRACTIC CLINIC, P.C.** to await payments from any source, and in the event **STINE CHIROPRACTIC CLINIC, P.C.** deems itself in its sole discretion insecure as to the prospect of payment, it may demand payments from me immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

I authorize **STINE CHIROPRACTIC CLINIC, P.C.** to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. I hereby nominate and appoint any officer of **STINE CHIROPRACTIC CLINIC, P.C.** as my attorney-in-fact to endorse/sign my name on any and all checks for payment of any indebtedness owed by me to **STINE CHIROPRACTIC CLINIC, P.C.** and to negotiate same for payment of the services provided to me by **STINE CHIROPRACTIC CLINIC, P.C.**

Witness my signature and seal as of the indicated date:

Printed Name: ______________________________ Date: _________________ SSN#: ____________________

Signature: __________________________________ (SEAL) Witness: ________________________________

STINE CHIROPRACTIC CLINIC

MONTHLY PAYMENT ARRANGEMENT ENROLLMENT FORM FOR PERSONAL INJURY

Authorization:

Due to the length of time it usually takes for personal injury claims to settle, I agree to a monthly payment arrangement with Stine Chiropractic Clinic, P.C. until my account has been paid in full. I understand that Stine Chiropractic Clinic does not discount their fees for personal injury cases and any unpaid balance will be my responsibility. In addition, any monies / funds received by me for services rendered by Stine Chiropractic Clinic, P.C., or settlement of my claim will be paid within 5 days of receipt of funds.

Payment Schedule & Fees:

Monthly payment arrangement will be $100.00 per month until payment in full is received (or the claims are denied and all other sources of third party payment have been reasonably exhausted as determined by Stine Chiropractic Clinic).

The total ending balance will be divided by 6, 12, 18, or 24 months (your option) and this will become your new monthly payment arrangement amount. (A balance of $500.00 or less must be paid within 12 months.)

Stine Chiropractic Clinic will extend a 5 day grace period after which a late fee of $25.00 will be applied. Any payment that is not received for the month due or that is received after the grace period will be charged a late fee with no exceptions. Non-payment for two consecutive months will cause the account to default this agreement and the remaining balance will be sent to Stine Chiropractic Clinic's collection agency, accruing 33⅓ % interest, attorney fees, and court costs.

Cancellation Terms:

This authorization is to remain in effect until the account balance is paid in full or the account holder gives written notification of intent to terminate this contract. The remaining balance is due in full upon termination of this contract. The account holder may suspend one payment (with 5 business days notice) to avoid non-payment fees; however the contract will resume on the next scheduled payment date.

I have read and agree to all terms set forth by Stine Chiropractic Clinic concerning deferred payment of my account balance.

______________________________ ________________

Signature **Date**

STAFF - FOR PATIENT RECORD

Account Number: __________ **Start Date:** ____________ **Staff:** ____________

STINE CHIROPRACTIC CLINIC

PLEASE COMPLETE THE FOLLOWING INFORMATION:

ACCOUNT HOLDER NAME: ______________________

NAME OF PATIENT (IF DIFFERENT) ______________________

STREET ADDRESS: ______________________

CITY, STATE, ZIP ______________________

BEST PHONE NUMBER TO REACH ME: ______________________

EMAIL ADDRESS: ______________________

PAYMENT WITHDRAW DATE: 1ST 15TH

PAYMENT AMOUNT: ______________________

PAYMENT TYPE ☐VISA ☐ MASTERCARD ☐ DISCOVER

ACCOUNT NUMBER: ______________________

EXPIRATION DATE: ______________________

SECURITY CODE: ______________________

ENDING BALANCE: ______________________

EFFECTIVE DATE: ______________________

NUMBER OF MONTHS: 6 12 18 24

AMOUNT PER MONTH: ______________________

ESTIMATED END DATE: ______________________