Auto Accident & Personal Injury

PATEINT NAME: _____**(M/ F)**

Damage of the Car : _____ **DATE OF ACCIDENT:** _____/____/____

Attorney's Information:_____

Person in charge:_____

Address:_____

Phone #:_____ **Fax #:**_____

Your Insurance Information	Other Party's Insurance Information
Company Name:	**Company Name:**
Insured:	**Insured:**
Policy #:	**Policy #:**
Claim#:	**Claim#:**
Adjustor Name:	**Adjustor Name:**
Phone #:	**Phone #:**
Medical Payment: $	

Your Health Insurance Information

Company Name:_____

ID #:_____

Telephone#:_____

ACCIDENT REPORT

1. What was your position in the vehicle?
   a. the driver b. front passenger c. rear passenger
   * Vehicle driven by? _____.

2. What type of vehicle were you driving?
   a. car b. truck c. van d. SUV
   - Your vehicle (year _____, make _____, model _____,color _____)
   - Time of day : □ Day time □ Dawn □ Dusk □Dark
   - Road condition: □ Dry □ Damp □ Wet □ Snow □ Ice □Other: _____.

3. What speed were you traveling at the time of the accident?
   a. speed _____ b. stopped c. moving slowly d. moving quickly

4. Who hit you?
   a. struck another vehicle b. struck *by* another vehicle c. struck stationary object

5. Where was your vehicle's point of impact?
   a. on the front b. on the rear c. left side d. right side

6. What speed was the other vehicle traveling?
   a. speed _____ b. stopped c. moving slowly d. moving quickly

7. Where was the other vehicle's point of impact?
   a. on the front b. on the rear c. left side d. right side

8. Were you wearing a seatbelt?
   a. lap and shoulder b. lap c. car seat d. none

9. What position were your vehicle head rests in?
   a. lowest b. Middle c. highest d. no head restraint
   - Was the position of headrest altered by the crash? □ Yes □ NO
   - Was the seat back adjustment altered by the crash? □ Yes □ NO
   - Was the seat broken? □ Yes □ NO

10. Did your airbag deploy? □ Yes □ NO

11. Were you prepared for the impact? □ Yes □ NO

12. What position was your body in just prior to impact?
   a. Straight position b. rotated to Left / Right c. can't remember

13. Did you struck any parts of the vehicle? □ Yes □ NO
   If yes, describe: _____

14. Did vehicle struck any objects in crash? □ Yes □ NO
   If yes, describe: _____

15. Wearing hat or glasses? □ Yes □ NO
   If yes, still on after crash? □ Yes □ NO

16. Did you lose consciousness? □ Yes □ NO

17. What happened to your body upon impact?
    a. body whipped backward and then forward
    b. body shipped forward and the backward
    c. body thrown from side to side
    d. body was torqued and twisted
    e. other: _____

18. What was your mental/ emotional state following the accident?
    a. conscious b. unconscious c. shaken up d. can't remember
    For how long? _____

19. Did you receive medical attention at the scene of the accident? □ Yes □ NO

20. How did you get to the ER or hospital after collision?

a. conscious b. unconscious c. shaken up d. can't remember

21. Did police officer(s) arrive to the scene? □ Yes □ NO

22. Did you get a ticket from police officer? □ Yes □ NO

23. Did you report your pain or discomfort to police officer or paramedic?
    □ Yes If yes, describe: _____ □ NO

24. Crash Description

_____

_____

_____

_____

_____

25. Crash Diagram

Signature:_____ Date:_____

Notice of Doctor's Lien

Patient's name: _____ Date of Accident: _____/_____/_____

I do hereby authorize _Jeong Hyee Kim, L.Ac_ to furnish you, my attorney, with a full report of her examination, diagnosis, treatment, prognosis, etc. of myself in regard the accident in which I was recently involved. I hereby authorize and direct you, my attorney, to pay directly to the said Doctor such sums as may be due and owing her for Medical services rendered to me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a lien on my case to said Doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

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

I agree to promptly notify said Doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning to the Doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the Doctor's interest, the Doctor will not await payment and may declare the entire balance due and payable.

_____ _____

Dated Patient's Signature

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict, as may be necessary to adequately protect and fully compensate said Doctor above-named. Attorney further agrees that in the vent this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

_____ _____

Dated Attorney Signature

* This office holds an assignment/lien on this case for services rendered. Any settlement of this claim without honoring assignment/lien will cause you to be responsible to this office for payment.

Financial Agreement Personal Injury

We would like to take a moment to welcome you to our office and to assure you that you will receive the very best care available for your injury. In order to familiarize you with the financial policy of our office, I would like to explain how your medical bills will be handled.

Party Responsibility

If you were involved in an auto accident in your own vehicle, we will bill the medical payments portion or Personal Injury Protection portion of your automobile insurance policy to cover the treatment charges incurred in our office.

Med Pay: If you were a passenger in another vehicle, the insurance company which ensures the automobile may be billed for your medical services incurred.

PIP: If you were a passenger in another vehicle, and you own a car which has PIP coverage, the insurance company which carries your policy will be responsible to pay your medical bills.

3rd Party: If another vehicle has caused the accident, we will first bill your automobile Med Pay or PIP policy for coverage PRIOR to submitting claim to the insurance carrier of the party at fault. If we rely solely on 3rd party settlement for payment, please understand that the insurance carrier will pay you directly upon settlement. By signing this form, you are agreeing to pay your balance in full within 3 days of receiving your settlement.

It is also to your advantage for our office to bill your own health insurance policy for your medical services, providing policy does not state otherwise. Any amount received above and beyond your total bill in this office will be refunded to you.

Attorney Liens

If you hire an attorney to represent you in a law suit, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any unpaid balance upon the settlement of your law suit. We retain the right to fire submit all charges to your private and/ or auto insurance policy for payment. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

Responsibility for Payment

As courtesy to you, we will gladly submit your charges to your insurance company and/or your attorney; however, all services rendered by this office are charged directly to you, and ultimately, you are personally responsible for payment of these charges regardless of any insurance reimbursement or settlement you may or may not receive.

Once again, we welcome you to our office. We hope that this has answered any questions that you might have about our financial arrangements. If, at any time, you have further questions about your care, please don't hesitate to ask.

I have read and agree to the above.

_____ _____

Patient's Signature Date