

Automobile Accident History Form

Your name: _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____ *AM / PM*

Street of Accident: _____ Heading *N / S / E / W*

City of Accident: _____

Road Conditions at the time of the accident: *WET / DRY / ICY / OTHER:* _____

List the year, make and model of the vehicle you were in:

Year: _____ Make: _____ Model: _____

Was the vehicle you were in stopped at the time of the impact? *YES / NO*

If yes, was the driver's foot also on the break? *YES / NO*

If no, then estimate the speed the vehicle you were in was moving at: _____ mph

If your vehicle was moving at the time of impact, was it?

SLOWING DOWN

SPEEDING UP

TRAVELLING AT A STEADY RATE OF SPEED

List the year, make and model of the other vehicle?

Year: _____ Make: _____ Model: _____

Was the other vehicle moving at the time of the collision? *YES / NO*

If yes, what was the approximate speed? _____ mph

If the other vehicle was moving at the time of the collision, was it:

SLOWING DOWN

SPEEDING UP

TRAVELLING AT A STEADY RATE OF SPEED

Which of the following vehicle parts broke during the accident? _____

What was the estimated cost damage to the vehicle you were in? \$ _____

Please describe, to the best of your knowledge, what happened during this accident:

(Please turn over)

Where were you seated in the vehicle? _____

Were you aware of the impending collision prior to the impact, or did the impact surprise you? **AWARE / SURPRISED**

Was the trunk of your body pointed straight forward? **YES / NO**

If no, what direction was it turned? _____

Was your head pointed straight forward? **YES / NO**

If no, what direction was it turned? _____

How far is the top of the headrest or seatback from the top of your head (approximately):
_____ inches **ABOVE / BELOW**.

Were you wearing a seatbelt? **YES / NO**

If yes, was it a **LAPBELT ONLY** or **SHOULDER AND LAPBELT**.

Did the police come to the accident scene? **YES / NO**; Is there a report? **YES / NO**

Did you go to a hospital? **YES / NO**, If yes:

What is the name of the hospital? _____

How did you get there? _____

What parts of your body were X-rayed? _____

What did the hospital do for your injuries? _____

How long did you stay at the hospital? _____

Was there any bleeding cuts sustained in the accident? _____

Was there any bruises sustained in the accident? _____

Did you receive any injury or bruising from your seat belt? **YES / NO**

Did you lose consciousness (black out) upon impact? **YES / NO**; How long? _____

Did you experience a flash of light or explosion in your head? **YES / NO**

On what part of the vehicle did your body parts hit?

WINDSHILED **FRONT SEAT** **RIGHT/LEFT SIDE**
WINDOW STEERING WHEEL **FRONT SEAT** **OTHER: _____**

Did you become?

CONFUSED

DISORIENTATED

LIGHT HEADED

DIZZY

NAUSEATED BLURRED

VISION

RINGING/BUZZING IN THE EARS

Immediately following the accident? If you still have any of these symptoms, which are they? _____

Are you currently suffering from any of the following?

RESTLESSNESS

DIFFICULTY CONCENTRATING

SLEEPLESSNESS

REDUCED TOLERANCE TO HEAT

IRRITABLE

REDUCED TOLERANCE TO

ALCOHOL FORGETFULNESS

DIFFICULTY WITH MEMORY

WATT FAMILY CHIROPRACTIC LLC

Dr. Britaney Watt

Dr. Bradley Watt

ASSIGNMENT OF BENEFITS

I, _____, hereby assign all rights, title, and interest from any and all automobile insurance policy which provides medical benefits or no-fault benefits to the Watt Family Chiropractic LLC, for payment for services rendered to me by Watt Family Chiropractic LLC for treatment of injuries sustained in the automobile accident which occurred on _____.

Patient

Date

In the event my Insurance Company fails to pay Watt Family Chiropractic LLC the full amount owing to Watt Family Chiropractic LLC after proper statutory notice, I hereby also assign the below cause of action to Watt Family Chiropractic LLC.

ASSIGNMENT OF CAUSE OF ACTION

I, _____, by this instrument assign all rights and causes of action in tort, in contract, and the Laws of Florida against my Personal Injury Protection Carrier _____, for its failure to pay or fully pay for services rendered to me by Watt Family Chiropractic LLC regarding injuries sustained in an accident which occurred on _____.

Patient

Date

Britaney Watt, D.C. Bradley Watt, D. C.

Date

WATT FAMILY CHIROPRACTIC LLC

Dr. Britaney Watt

Dr. Bradley Watt

ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN AND TRANSFER ANY AND ALL RIGHTS, BENEFITS AND CAUSES OF ACTION TO THE ASSIGNEE. This is an assignment of my rights and benefits. In the event my insurance company is obligated to make payment to me upon charges made by the Assignee for its services, and the company fails or refuses to make timely, complete payment, I authorize Assignee to prosecute said cause of action either in my name or Assignee's name and further I authorize Assignee to compromise, settle or otherwise resolve said cause of action as they see fit.

DIRECTION OF PAYMENT

I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to _____ (**Assignee**), such sums as may be due and owing Assignee for the services rendered to me both by reason of accident or illness, and by reason of any other bills that are due Assignee. I hereby authorize any insurance company to pay directly to Assignee the amount of this and/or any future bills for services rendered to me and to release any information requested that is pertinent to my case to my insurance company or attorney involved in this case.

LETTER OF PROTECTION IN FAVOR OF PROVIDER

I hereby authorize and direct that my lawyer, if I am represented by counsel, SHALL withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, or any other insurance benefits obligated to reimburse me, or, from any settlement, judgment or verdict on my behalf as may be necessary to reimburse Assignee for services provided to me. I HEREBY FURTHER GIVE AN IRREVOCABLE LIEN to said Assignee against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the Assignee. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to Assignee.

PIP LOG & DEC SHEET REQUEST

I HEREBY AUTHORIZE THE ASSIGNEE TO REQUEST A COPY OF THE APPLICABLE INSURANCE POLICY AND DECLARATION PAGE WHICH REFLECTS THE POLICY LIMITS AVAILABLE AT THE TIME OF THIS ACCIDENT, AND THE APPLICABLE PIP LOG TO BE PROVIDED TO THIS ASSIGNEE upon request. This request is authorized pursuant to the terms of my policy as well as Florida Statutes. I hereby authorize this Assignee to request and receive a copy of my pip log periodically as they deem to be necessary.

RESERVATIONS OF BENEFITS

Be further advised that I AM HEREBY PLACING YOU ON NOTICE PURSUANT TO FLORIDA CASE LAW THAT SHOULD YOU (THE INSURANCE COMPANY/CARRIER) DENY, REDUCE OR FAIL TO PAY ANY PART OF, OR AN ENTIRE BILL WHICH WAS SUBMITTED ON MY BEHALF FROM THIS PROVIDER, I (THE ASSIGNOR) AS WELL AS THE ASSIGNEE ARE REQUESTING IN ADVANCE THAT YOU RESERVE, OR "SET-ASIDE," THE AMOUNT YOU REDUCED OR DENIED UNTIL THE DISPUTE IS RESOLVED. Should you submit a check to Assignee which is less than the correct contractual amount, and contains any language referring to payment as "Full and Final Payment," I have instructed Assignee to return the check to you (the carrier) and consider the bill still due and owing (i.e. a late payment as defined in F.S 627.736). Additionally SHOULD THE REMAINING AMOUNT OF MY BENEFITS APPROACH AN AMOUNT WHERE THERE WOULD BE INSUFFICIENT FUNDS TO PAY THE AMOUNT YOU REDUCED, DENIED OR FAILED TO PAY, PLEASE NOTIFY ME (THE ASSIGNOR) AND THE ASSIGNEE OF THIS FACT. Should my benefits exhaust; please notify me (the assignor) and assignee promptly.

SEVERABILITY CLAUSE

If any term or provision of this Assignment, Lien and Authorization or the application thereof to any person or circumstances shall to any extent be invalid or unenforceable the remainder of this Assignment, Lien and Authorization, or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and each term and provision of this Assignment, Lien and Authorization shall be valid and enforced to the fullest extent of the law.

Signature _____

Date _____

Print Name _____

Date _____

WATT FAMILY CHIROPRACTIC LLC

Dr. Britaney Watt

Dr. Bradley Watt

Date: _____
Attn: _____
Patient _____
Date of Loss : _____

I, _____ hereby instruct my attorney/legal representative to pay from the proceeds of any net recovery (after the payment of attorney fees and costs) all outstanding amounts owed to **Watt Family Chiropractic LLC**, for medical care or services. I agree that I am responsible to the above named health care provider for the payment of all services rendered to me, regardless of the outcome of my case. I am instructing my attorney / legal representative to pay **Watt Family Chiropractic LLC**, any outstanding charges, at the time of recovery. My attorney in no way accepts any direct or personal liability for any medical bills, expenses or the payment of amounts owed to my health care provider.

Protection of Outstanding Charges: If the above-named client recovers money damages from any person or entity responsible for charges incurred by **Watt Family Chiropractic LLC**, the client agrees to instruct their legal representative to withhold sufficient funds, after deduction of attorney's fees and costs, to pay outstanding medical bills for any and all charges owed to **Watt Family Chiropractic LLC** in connection with the accident or event giving rise to and covered by the recovery and not covered by any collateral source.

Balance Confirmation: **Watt Family Chiropractic LLC** will furnish your legal representative periodically with outstanding charges. It is your responsibility to ensure that your legal representative has requested an updated balance when recovery is imminent.

Pro Rata Distribution if Inadequate Recovery: If the net recovery is less than the total outstanding charges owed to **Watt Family Chiropractic LLC**, funds may be distributed on a pro rata basis.

Disputes: If the above named client disputes any outstanding charges or claims a setoff and we are unable to resolve the issue with your legal representative, the amount of the disputed charge / setoff will be deposited into the court registry for judicial determination.

Approval Required: By signing this agreement, I agree to pay outstanding charges to **Watt Family Chiropractic LLC** at the time of recovery. If I fail to do so, all outstanding charges become my financial responsibility with the addition of interest and the possibility of collection proceedings if not paid in full. This agreement becomes effective when you, the client named above, approve it in writing in the place provided below. A photocopy of this document shall be considered as effective and valid as the original and will be forwarded to your legal representative. **This Lien cannot be rescinded without notification to Watt Family Chiropractic LLC.**

Patient / Guardian Date Witness Date

Attorney Date

WATT FAMILY CHIROPRACTIC

Dr. Britaney Watt

Dr. Bradley Watt

This is to certify that the below signed is a patient of Watt Family Chiropractic, LLC, and is receiving Chiropractic care for injuries sustained in an auto accident.

Per your request and/or the request of your attorney, you have asked this clinic to submit the charges for services rendered to a supplemental insurance carrier. This is a supplemental insurance policy to your personal injury protection covered by your auto insurance policy.

By signing below, you understand that any payment received by your insurance company, if not paid in full will act as a supplemental payment which will go towards your outstanding balance.

If this clinic is under contract to a group health policy under an HMO/PPO or capitation arrangement, any payment received will not be considered as payment in full, but rather a supplement to your outstanding balance and will be credited to your account as such.

Our clinic will be happy to continue to work with you and your attorney under a Letter of Protection to defer payment until settlement is reached if necessary.

I understand that I remain personally liable for payment services rendered.

I certify that I have read and understand the above.

Patient's signature

Date

Print Name

Witness signature

Date

Print Name



Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered**. This means that those services have **already been provided**.

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to \$500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name (<i>PRINT or TYPE</i>)	Signature	Date
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The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

- A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.
- B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.
- C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.
- D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable (*Signature by his/ her own hand*):

Name (<i>PRINT or TYPE</i>)	Signature	Date
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Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.