

## AUTO ACCIDENT INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Insurance Company to be billed: \_\_\_\_\_

Insurance Company Contact Person: \_\_\_\_\_

Contact Person Phone Number: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Approx. Time of Accident: \_\_\_\_\_

Name of the location/street on which the accident occurred: \_\_\_\_\_

Were you the:  Driver  Front passenger  Rear passenger

What type of vehicle were you in?  Car  SUV  Mini Van  Conversion Van

Pickup Truck  Bus  Semi  Motorcycle

Was this vehicle equipped with airbags?  Yes  No Did the airbags inflate?  Yes  No

Were you wearing a seat belt?  Yes  No Vehicle you were in:  Struck  Was struck by

With what did the accident occur?  Another vehicle  Tree  Ditch  
 Guardrail  Pedestrian  Motorcycle  
 Cement barrier  Semi-tractor trailer  Deer

On which side of your vehicle was the impact?  Front  Rear  Driver's side  Passenger's side  
 Front driver's side  Back driver's side  
 Front passenger's side  Back passenger's side

In relation to the base of your skull, where was the head rest?  Above  Below  
 At the base of

What was the motion of your vehicle upon impact?  Stopped  Turning right  Turning left  
 Accelerating  Decelerating

What were the road conditions at the time of the accident?  Dry  Wet  Snowy  Icy  Slippery

**How was the visibility?**      Excellent      Good      Poor

**What were the visibility factors?**      Bright sunshine      Rain falling      Snow falling  
Nighttime darkness      Dawn      Dusk      Fog

**During impact, were you facing:**      Forward      Right      Left

**Which direction were you looking?**      Forward      Right      Left      Behind      Up      Down  
In the rear view mirror      In the side view mirror

**Were you:**      Surprised and not braced for impact      Somewhat prepared but not braced for impact  
Prepared but not braced for impact      Prepared and braced for impact

**Did any part of your body strike anything in the vehicle?**      Yes      No

**What part of the body?** \_\_\_\_\_

**What did that part of your body hit?** \_\_\_\_\_

**How did you feel immediately after the accident?**      Stunned      Disoriented      Frightened  
Angry      Felt tightness/stiffness  
Felt mild discomfort/pain  
Felt moderate discomfort/pain  
Felt severe/intense discomfort/pain

**Did you go to the emergency room immediately after the accident?**      Yes      No

**How did you leave the accident scene?**      my own vehicle      another vehicle  
ambulance      walking

**Have you gone to the hospital or seen any other doctor since the accident?**      Yes      No

**When did you go?**      Same day      Next day      2 or more days later

**Name of the Hospital and/or attending doctor?** \_\_\_\_\_

**Were any x-rays taken?**      Yes      No      **Explain:** \_\_\_\_\_

**Was medication prescribed?**      Yes      No      **Explain:** \_\_\_\_\_





Dr. Melissa Kelling  
Dr. Lisa Geurink  
902 5<sup>th</sup> Street, P. O. Box 715  
Durant IA 52747  
Phone: 563-785-6511 Fax: 563-785-5011  
www.durantchiropractic.com

## AUTO ACCIDENT POLICY

### BILLING YOUR AUTO INSURANCE

Your Med Pay provision on your personal automobile insurance policy allows payment to our office for your charges as you progress through treatment. The amount of Med Pay coverage always varies from policy to policy. Your insurance company will negotiate with the liable party to obtain a lump-sum reimbursement directly to them. Utilizing your Med Pay provision typically does not affect the premium on your car insurance.

It is our office policy that we do not allow large balances to accrue on our patient's accounts. Therefore, if your treatment should extend beyond three months, or if your charges exceed \$1,000, we ask that you pay your charges at the time of service for any further treatment.

Please remember that you are ultimately responsible for your charges at this office, and that Durant Chiropractic Clinic will not become involved in disputes over payment or liability, other than to provide factual information. If you have any questions regarding this policy or your insurance coverage, please ask an office representative.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_



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## AUTHORIZATION TO PAY THE DOCTOR

I hereby authorize the \_\_\_\_\_(insurance company)

to pay by check and mail directly to:

Durant Chiropractic Clinic  
902 5<sup>th</sup> Street  
PO Box 715  
Durant, IA 52747

The expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to above named assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Date: \_\_\_\_\_



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## DOCTOR'S LIEN

To: Attorney/Insurance Carrier

Doctor:

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RE: Patient records and doctor's lien

I, \_\_\_\_\_, do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of her case history, examination diagnosis, treatment plan and prognosis of myself in regards to my accident/injury which occurred on \_\_\_\_\_.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/injury, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing her for services rendered to me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect said doctor adequately.

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

Patient's signature: \_\_\_\_\_

Dated: \_\_\_\_\_