



Lake Country Health Center

Dr. Daniel T. Murray and Associates

chiropractic, spinal decompression, sports injury, acupuncture, nutrition & massage

Motor Vehicle Accident Policy

If you've been involved in a car accident, you will need a consultation with Dr. Murray & Dr. Meye, to evaluate your injuries sustained due to the motor vehicle accident. This is true regardless of whether you're pursuing a claim or just want to make sure you are fine and don't require any further treatment.

Injuries caused by motor vehicle accidents are not always obvious. It is necessary to seek early and appropriate evaluation and treatment for all types of injuries, if necessary, to avoid pain, suffering, and possible permanent damage to soft tissue. Although, you might not see any tissue damage or have any broken bones, you can still end up with long-term back or neck pain, if damages aren't assessed and addressed. Treatment at Lake Country Health Center for injuries that have been sustained as a result of an auto accident are billed directly to your auto insurance company through your Medical Payments Coverage/Medpay. We will also have a "Doctor's Lien" signed, which states that you would be responsible to pay for care with your settlement, in the event that claims are not paid directly by the insurance company.

If you have been injured in a collision, please follow the process below.

Within 10 days of the collision:

1. File an accident report with the police.
2. Contact your auto insurance company and the other driver's auto insurance company.
3. Seek evaluation and treatment for your injuries (i.e. sprain, strain or minor whiplash injury), as soon as possible.
4. Following through with care/treatment plan provided is of utmost importance to reach pre-injury status of health and to allow the insurance company to pay claims in full on your behalf. Please Note: You do not need prior authorization to seek treatment for injuries.
5. Inform your auto insurance company that you are treating for injuries sustained in the motor vehicle accident. They will provide you with a claim number and medical claims adjuster's name/phone number. Please provide our office with this information, so that we may process your claims and send them to the appropriate department.
6. If at any time you have questions regarding this process, treatment, additional care options, claims, etc., PLEASE DO NOT HESITATE TO ASK! We are here to help you feel better as soon as possible!

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Patient Name _____

Date of Accident _____ Time of Accident _____ a.m.

p.m.

Please describe the accident in your own words: _____

Were you the: Driver Front Passenger Rear Passenger Pedestrian

How many people were in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest intersection with road/street _____

Driving conditions Dry Wet Icy Other _____

Which direction were you headed? _____

Speed you were traveling? _____

VEHICLE

Make and model of vehicle you were in: _____

Were you wearing a seatbelt? Yes No
If yes, what type? Lap Shoulder

Was vehicle equipped with airbags? Yes No
If yes, did it/they inflate properly? Yes No

Did your seat have a headrest? Yes No
If yes, what was the position of the headrest?
 Low Midposition High

IMPACT

Did your car impact another vehicle? Yes No

Did your car impact a structure? Yes No

If yes, explain _____

Did any part of your body strike anything in the vehicle?

Yes No If yes, explain _____

Was impact from :

Front Rear Left Right Other _____

At the time of impact were you:

Looking straight ahead Looking to the right
 Looking to the left Looking down
 Looking up

Were both hands on the steering wheel? Yes No
If no, which hand was on the wheel? Right Left

Was your foot on the brake? Yes No
If yes, which foot was on the brake? Right Left

Were you: Surprised by impact Braced for impact

OTHER VEHICLE

(If applicable)

Make and model of other vehicle _____

Which direction was other vehicle headed? _____

Speed other vehicle was traveling _____

POLICE

Did the police come to the accident site? Yes No

Were there any witnesses? Yes No

Was a police report filed? Yes No

Was a traffic violation issued? Yes No

If yes, to whom? _____

PATIENT CONDITION

Were you unconscious immediately after the accident? Yes No If yes, for how long? _____

Please describe how you felt immediately after the accident:

TREATMENT

Did you go to the hospital? Yes No

When did you go? Immediately after accident Next day 2 days or more after the accident

How did you get to the hospital? Ambulance Private transportation

Name of hospital _____ Name of doctor _____

Diagnosis _____

Treatment received _____

X-rays taken _____

SYMPTOMS/INJURIES

Have you been able to work since this injury? Yes No How many work days have you missed? _____

Prior to the injury were you able to work on an equal basis with others your age? Yes No

If you have had any of the following symptoms since your injury, please check:

- | | | |
|--|---|--|
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Feet/toe numbness | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Hand/finger numbness | <input type="checkbox"/> Neck stiff |
| <input type="checkbox"/> Back stiffness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sleep difficulty |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Ear buzzing | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Ear ringing | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Vision blurred |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nausea | |

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

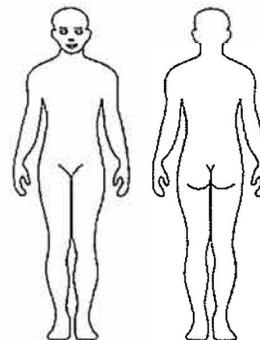
Type of pain: Sharp Dull Throbbing Numbness
 Aching Shooting Burning Tingling
 Cramps Stiffness Swelling Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Movements that are painful to perform: Sitting Standing Walking
 Bending Lying Down



To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient



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Personal Injury Information

Patient Name: _____

Type of Accident: _____ Reported to Police: _____

Date of Accident: _____ Time of Accident: _____

If this is due to an auto accident, MedPay is the medical coverage you have under your auto insurance policy.

Insured's Name: _____

Insurance Carrier: _____

Address: _____

City/ST/Zip: _____

Policy Number: _____

Claim Number: _____

Claim Adjuster Name: _____

Phone Number for claims: _____

Fax Number for claims: _____

I, the undersigned assign directly to Lake Country Health Center / Dr. Daniel T. Murray all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient or Guardian Signature: _____ ; **Date:** _____

If you have contacted an Attorney regarding this injury or accident, please give us the following information, as the attorney will receive a statement of fees as well.

Attorney Name: _____

Address: _____

City/St/Zip: _____

Attorney Phone Number: _____



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**Authorization for
Release of Records &
Physician's Lien**

TO:

Attorney Name or Insurance Carrier Name _____

Attorney At Law _____

Attorney or Insurance Street Address _____

Attorney or Insurance Carrier City, State Zip _____

RE: PATIENT RECORDS RELEASE AND DOCTOR'S LIEN

Ref Patient Name: _____

Account #: _____

RELEASE OF RECORDS: I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of his or her 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 said doctor 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 said doctor 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 said doctor adequately.

ASSIGNMENT OF BENEFITS: I further assign my claim or right to compensation for treatment expenses incurred with the doctor/clinic named above arising from a tort or liability claim in connection with this accident or injury.

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 understand that I am directly and fully responsible to said doctor/clinic for chiropractic bills submitted by him or her for service rendered me, and that this agreement is made solely for said doctor's additional protection and in consideration of his 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.

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 the above named doctor/clinic as per SCR 20:1.15(b). In additional consideration to the above, for executing this lien, the doctor/clinic will provide the attorney with billing summaries and availability to discuss the patient's care on a reasonable basis. The attorney may further protect his or her lien interest for compensation by having a priority status over this lien.

Auth. Signature: _____

Dated: _____

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

This form (or a suitable "Letter of Protection" from the attorney) must be executed by both the patient and the patient's attorney before this clinic will consider awaiting settlement for payment of services rendered in this case.