PERSONAL INJURY VERIFICATION
Medical payments/PIP/No-Fault

Patient: _____ Insured: _____

Policy#: _____ Claim # _____

Date of Injury: _____ Adjuster's name: _____

Relationship to Insured: (circle one) SELF FAMILY MEMBER OTHER

Has the accident been reported? YES NO Has a medical file been opened? YES NO

Medical limits: _____ What's left: _____

Benefits paid directly to doctor? YES NO If no, payable to patient and mailed to doctor? YES NO

Insurance Company Billing Address/Information

Name: _____

Address: _____

City, ST, ZIP _____

Phone: _____

Code: _____

Attorney Information

Attorney name: _____ Want bills? YES NO

Address: _____ Accept and honor lien: YES NO

City, ST, Zip: _____ Atty. Contact name: _____

Phone: _____

Fax: _____

Automobile Accident History

Name:_____ Age:_____ Date of Birth:_____ M____ F____

Address:_____

City: _____State: _____ Zip:_____

SS# _____ Drivers License #_____

Insurance Company: _____ Name of Agent: _____

Address of Insurance Company: _____

Have you retained an attorney? Y _____ N _____ Name and Address of Attorney: _____

_____

General Symptoms:

Did you hit any part of your body during the collision, for example: head on dash, chest on steering wheel? Y___ N___

If so, which part and how? _____

_____

Where were you taken after the accident?_____

Were you hospitalized? Y _____ N_____ If Yes, for how long? _____

Did you receive care from any other health care specialist? Y ___ N ___ If so, what was the specialist name?

_____

What type of care were you given and for how long? _____

Where did you feel the pain? _____

What are your current symptoms? _____

Have you ever been injured in a similar manner? Y ___ N ___ If yes, how and when? _____

_____

Accident History:

Date of accident: _____ Time of accident: _____ A.M.____ P.M. ____

State how accident happened in your own words: _____

_____

_____

What type vehicle were you in? Make: _____Year: _____

Were you driving? Y___ N ___ Was it your car? Y ___ N ___ If not, whose?_____

Passenger? Y N Front Seat? Y N Back Seat? Y N Right Side? Y N Left Side? Y N Were you rotated in seat? Y N

Were you reclined? Y N Other: _____ Other people in the car? Y N

Names Addresses: _____

Were they injured? Y N If yes, explain:_____

Seat belts on? ❑ Yes ❑ No Shoulder harness on? ❑ Yes ❑ No Position of Headrest: _____

Was it? ❑ Daylight ❑ Night ❑ Dusk ❑ Dawn What were the weather conditions? _____

Were you tired? ❑ Yes ❑ No Were you awake? ❑ Yes ❑ No How long had you been in the car? _____

Where were you prior to the accident? _____

What were the traffic conditions? _____ What was the posted speed limit? _____

How fast were you going? _____ Type of road: ❑ 2 Lane ❑ 4 Lane ❑ Gravel ❑ Tar

Did it happen at a/an: ❑ stop sign ❑ traffic light ❑ intersection ❑ highway

Was your car hit? ❑ Front ❑ Back ❑ Left Side ❑ Right Side What damage was done to your car?

Inside: _____

Outside: _____

Other: _____

If you struck another car, did you strike it: ❑ Front ❑ Back ❑ Side What was the damage to the other car?

Inside: _____

Outside: _____

In what condition was the vehicle prior to the accident? _____

Do you have pictures of the involved automobile? ❑ Yes ❑ No What type of vehicle was involved in the accident?

❑ Car ❑ Truck ❑ Motorcycle ❑ Other: _____ Size and Type: _____

Was accident report made? ❑ Yes ❑ No Police of: City: _____ County: _____ State: _____

Who was ticketed? _____ For what? _____

Did your vehicle strike anything? ❑ Yes ❑ No If yes, ❑ Another car ❑ Sign ❑ Tree ❑ Bridge ❑ Hedge

❑ An Embankment ❑ Other: _____ Size and Type: _____

Were you completely conscious after the impact? ❑ Yes ❑ No

Do you remember the impact? ❑ Yes ❑ No Did your vehicle go off the road? ❑ Yes ❑ No

If so, ❑ Into a ditch? ❑ An Embankment? How Deep? _____

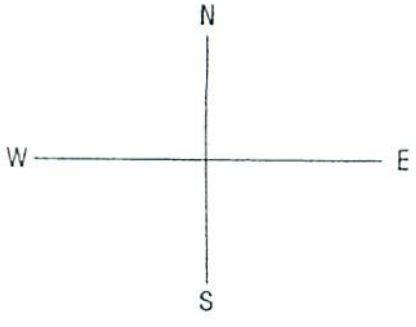
Does it bother you to ride in a car now? ❑ Yes ❑ No If so, as a ❑ Driver ❑ Passenger

State any strange events that happened during or immediately after the accident. _____

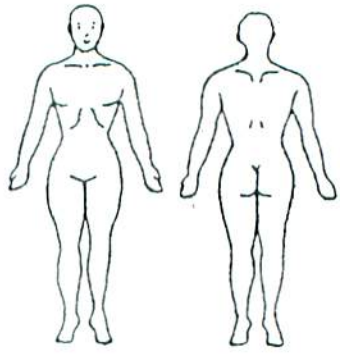
_____

Have you had any time loss from work? ❑ Yes ❑ No If yes, from _____ to _____

Have you had to have any outside help? ❑ Yes ❑ No What type? _____



PLEASE DRAW THE ACCIDENT



MARK PAIN AREA

+++ Burning
000 Stabbing
- - - Sharp
III Constant

_____ Patient Signature

_____ Date

_____ Staff Signature

INGRAM HEALTH CARE, P.C.
CHIROPRACTIC • ACUPUNCTURE • REHAB

Kristofer Ingram, D.C.
Tina Ingram, D.C.

ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to the physician or facility named above the following rights, power and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney, or insurance adjuster, for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned to the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owned by an insurance company, in accordance with *Article 21.55* of Texas Insurance Code or other applicable insurance or state statute. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above **within 60 days** following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we personally owe which are not payable under the terms of the policy. This demand specifically conforms with *Article 21.55* of the Texas Insurance Code, providing for attorney fees, 18% penalty, court costs, and interest from judgment, upon violation.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to cut a separate draft to pay in full all services rendered, payable directly to the physician/facility named above.

STATUTE OF LIMITATIONS: I waive my right to claim any Statute of Limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable coasts of collection, including attorney fees and court costs if incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this chiropractic clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If, during the course of my care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.

A photocopy of this instrument shall serve as original.

Signature of Patients and/or responsible parties:

1. _____ Date _____

2. _____ Date _____

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