**Parliament Chiropractic, LLC**
**Automobile Collision Personal Injury Form**

***If the injury you are seeking treatment for did not result from an automobile collision, please alert the receptionist.***

**General Information:**

Patient's Name:_____ Today's Date:_____ Date of Injury:_____
Did your injuries occur in the course of employment/on the job? Yes ☐No ☐(If Yes, please alert receptionist)
Please explain how the accident occurred: _____
_____
Where are you hurting as a result of the accident? _____
_____
Have you ever had an injury to the same area where you are hurting now?☐Yes ☐No
If "Yes" state when and how you were injured:_____
_____
Have you lost any days of work? ☐ Yes ☐ No Dates:_____ Date last worked:_____
Was a police report filled out? ☐Yes ☐ No If so, in what city was it filed? _____
Did you require post-accident hospitalization (Emergency Room)? ☐Yes ☐ No
If "Yes", hospital name:_____ Treatments done (including Ambulance, X-rays, etc):_____

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**Billing Information:**

**If you do not provide correct and complete information, you will be personally billed for your treatment. Billing the auto insurance company is a courtesy and if the information is not correct we will send the bills to you. Please call your adjustor BEFORE filling this form out to confirm your claim number, their contact information, and their fax number.**

Name of insurance company or entity being billed for your treatment: _____
Have you filed a claim with the insurance company you intend to bill for treatment? ☐Yes ☐ No
Name of adjustor: _____ Claim Number:_____
Adjustor phone number: _____ Fax Number: _____
Have you retained an attorney to represent you? ☐ Yes ☐ No
Attorney's Name: _____ Company Name: _____
Phone: _____ Fax: _____

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**Details for Auto Collision:**

Location of the accident: _____
You were: ☐ Driver ☐Front-seat passenger ☐Rear seat passenger ☐Motorcycle rider ☐Motorcycle passenger ☐Other
Vehicle Driven By (If you were not the driver): _____
Your vehicle (year, make, model):_____
Your estimated speed at the moment of crash:_____ ☐Stopped ☐ Slowing ☐ Accelerating
Other vehicle (year, make, model):_____
Other vehicle estimated speed at the moment of crash:_____ ☐Stopped ☐ Slowing ☐ Accelerating
Did your car strike other(s) involved? ☐Yes ☐No Or did the other car strike yours? ☐Yes ☐ No
Which party was at fault? _____.
Time of Accident:_____ ☐AM☐PM Road conditions: ☐Dry ☐Damp ☐Wet ☐Snow ☐Ice ☐Other:_____
Were you seat-belted upon impact? ☐ Yes ☐No Were any airbags deployed? ☐Yes ☐No
At the time of impact, was your head: ☐Facing forward ☐To the left ☐To the right
Did anything out of the ordinary happen (ex: glasses jerked off face, hat jerked off head, etc.)?
_____
Name of the insurance company covering the vehicle that you were driver/passenger in: _____
Name of the insurance company covering the other vehicle: _____

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**PATIENT'S SIGNATURE:** _____ **DATE:**_____

Return to:
Parliament Chiropractic, LLC
*2665 E. Tudor Rd, Suite 201*
*Anchorage, AK 99507*
*Phone: (907)222-5100 Fax: (907) 222-5412*
www.ParliamentChiropractic.com

# Third Party Medical Lien and Assignment
# Anchorage Recording District

Patient: _____

Claim #: _____

Date of Injury: _____

I do hereby authorize Parliament Chiropractic, LLC to furnish my attorney/insurance carrier with a full report of case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness of this case.

I hereby authorize and direct _____ Insurance Company and or Attorney to pay Parliament Chiropractic, LLC such sums as may be due and owing for chiropractic services rendered me by reason of the accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate Parliament Chiropractic. And I hereby further request that payments be made directly to said provider which would otherwise be paid to myself, as the result of the treatment charges incurred for injuries in connection with this accident. This is a direct assignment of my rights and benefits.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by Parliament Chiropractic, LLC for services rendered me and this agreement is made solely for Parliament Chiropractic's protection and consideration for payment. And I further understand that such payments are not contingent on any settlement, judgment or verdict which I may eventually recover.

Patient Signature: _____ Date: _____

# Parliament Chiropractic, LLC

## Billing and Collection Policy and Procedure for Third-Party Liability Accounts

## Objective

Parliament Chiropractic, LLC hereby informs patients who are seeking chiropractic or massage treatment because of an automobile or other accident of Parliament Chiropractic's policy and procedure for billing and collection on accounts where third-party insurance liability exists.

A patient that is seen by Parliament Chiropractic who is receiving third-party insurance coverage is hereinafter referred to as a "Third-Party Coverage Patient" or "TPC Patient".

## Third-Party Liability and Coverage

In this Policy and Procedure, third-party coverage means payment provided by a third-party insurer, and not by the patient's primary insurance provider, for any third-party liability that is the result of an automobile or other accident.

## Billing and Collection Process of Third-Party Liability Accounts

### A. General

Parliament Chiropractic uses reasonable efforts and follows a reasonable process for collecting amounts due for services provided to all patients, including patients who are being seen because of an automobile or other accident that constitutes a third-party liability.

Parliament Chiropractic will make reasonable and diligent efforts to investigate whether a third-party resource may be responsible for the services provided to a patient, including but not limited to: (1) a motor vehicle or homeowner's liability policy, (2) general accident or personal injury protection policies, or (3) worker's compensation programs.

If Parliament Chiropractic has prior knowledge and is legally able, it will attempt to secure assignment of a patient's right to third-party coverage or settlement on services provided due to an accident, as further described below.

### B. Collection Notices

Parliament Chiropractic shall seek payment in full for services it has provided from the appropriate party, whether that is the third-party providing payment for a TCP Patient or

from a patient when the account is considered a “Self-Pay.” Parliament Chiropractic reserves the right to utilize outside vendors, such as a third-party collection agency, to assist it and its patients regarding balances due, payment plans, etc.

### C. Self-Pay Determination

A third-party liability account is determined to be Self-Pay if:

1. The patient does not provide information requested from the third-party insurer(s) sufficient to process the claim(s);
2. The third-party insurer(s) has provided a check directly to the patient for subsequent payment to Parliament Chiropractic, but the patient fails to make the required payment; or
3. If all payments have been received from the third-party insurer(s) but there is still a remaining balance due on the patient’s account.

All patients with a third-party liability account that has been determined to be in a Self-Pay status will be sent a minimum of three (3) statements before the account is in default. After a minimum of three statements, Parliament Chiropractic may take further collection action in an attempt to collect the debt. This process may be supplemented by other notification methods that constitute a genuine effort to contact the party responsible for the obligation, including but not limited to: telephone calls, text messages, collection letters, personal contact notices, and computer notifications.

If Parliament Chiropractic deems it necessary to pursue further collection action, it may choose to pursue legal action to attempt to obtain a court-ordered judgment, which may then be used to garnish the patient’s Alaska Permanent Fund Dividend (PFD), wages, or bank account(s).

## Required Information and Forms from Third-Party Coverage Patients

In addition to standard patient information, Parliament Chiropractic requires a TPC Patient to provide information about the third-party that is providing payment for treatment costs in a manner that is sufficient for Parliament Chiropractic to successfully file a claim for payment.

Parliament Chiropractic also requires a TPC Patient to sign a Third-Party Medical Lien and Assignment (“Lien”), which authorizes Parliament Chiropractic to provide a full report of the TPC Patient’s case history, examination, diagnosis, treatment, and prognosis to the TPC Patient’s attorney and/or the third-party providing payment for the TPC Patient’s accident or illness for which they are being treated. The Lien also authorizes and directs the third-party to directly pay Parliament Chiropractic the sums that are due and owing for the treatment Parliament Chiropractic is providing to the TPC Patient. The Lien further states that the document serves as a direct assignment of the TPC Patient’s rights and benefits, and that the Lien is solely for Parliament Chiropractic’s protection and consideration for payment.

The TPC Patient must also communicate with the third-party providing payment for treatment that if any payment is provided directly to the TPC Patient that Parliament Chiropractic must be added as an additional payee. In the event the TPC Patient receives payment for Parliament Chiropractic's services and Parliament Chiropractic has not been added as an additional payee, the TPC Patient acknowledges that they shall immediately remit the amount of the third-party payment to Parliament Chiropractic.

Finally, Parliament Chiropractic requires all TPC Patients to sign an acknowledgement of receipt and understanding of: (1) this Billing and Collection Policy and Procedure for Third-Party Liability Accounts, and (2) the Lien.

_____

Patient/Guarantor Signature

_____

Date

Parliament CHIROPRACTIC

2665 E. Tudor Rd #201
Anchorage, AK 99507

# Functional Activities of Daily Living

***This form is to be filled out by all Personal Injury and Worker's Compensation cases.**

Please identify how much difficulty you have performing each of the below tasks:

1. Personal Care (Bath/Hygiene)
    a. I do not have to change my personal care habits to avoid pain.
    b. I do not change my personal care habits although it causes some pain.
    c. My personal care habits do increase my pain but I do not change my normal routine.
    d. My personal care habits do increase my pain to a point where I find it necessary to change my normal routine.
    e. Due to the pain, I am unable to perform some of my normal personal care habits.
    f. Due to the pain, I am unable to perform any of my normal personal care habits.

2. Daily Household Chores
    a. I do not have to change my daily household chores to avoid pain.
    b. I do not change my daily household chores although it causes some pain.
    c. My daily household chores do increase my pain but I do not change my normal routine.
    d. My daily household chores do increase my pain to a point where I find it necessary to change my normal routine.
    e. Due to the pain, I am unable to perform some of my normal daily household chores.
    f. Due to the pain, I am unable to perform any of my normal daily household chores.

3. Sleeping
    a. I have no pain or interruptions in my sleep.
    b. I get some pain in bed but it does not prevent me from my normal sleeping patterns.
    c. Due to the pain I get in bed my sleeping patterns are mildly disturbed (approximately ¼ night's sleep).
    d. Due to the pain I get in bed my sleeping patterns are moderately disturbed (approximately ½ night's sleep).
    e. Due to the pain I get in bed my sleeping patterns are severely disturbed (approximately ¾ night's sleep).
    f. Due to the pain I get little to no sleep at all.

4. Sitting
    a. I can sit in any chair as long as I like without pain.
    b. I can sit in any chair as long as I like with only a mild increase in pain.
    c. Pain prevents me from sitting for more than 1 hour.
    d. Pain prevents me from sitting for more than ½ hour.
    e. Pain prevents me from sitting for more than 15 minutes.
    f. Pain prevents me from sitting at all.

5. Standing
    a. I am able to stand as long as I want without pain.
    b. I am able to stand as long as I want with only mild pain.
    c. Pain prevents me from standing for more than 1 hour.
    d. Pain prevents me from standing for more than ½ hour.
    e. Pain prevents me from standing for more than 15 minutes.
    f. Pain prevents me from standing at all.

6. Walking
    a. I am able to walk as long as I want without pain.
    b. I am able to walk as long as I want with only mild pain.
    c. Pain prevents me from walking for more than 1 hour.
    d. Pain prevents me from walking for more than ½ hour.
    e. Pain prevents me from walking for more than 15 minutes.
    f. Pain prevents me from walking at all.

7. Lifting Objects
    a. I am able to lift heavy objects without any extra pain.
    b. I am able to lift heavy objects but it mildly increases my pain.
    c. Pain prevents me from lifting heavy objects from the floor, but I can manage them if they are conveniently positioned, e.g. on a table.
    d. Pain prevents me from lifting heavy objects but I can manage light to medium weights.
    e. Due to the pain, I can only lift very light weights.
    f. Due to the pain I am unable to lift any weight from the floor.

8. Driving
    a. I am able to drive as long as I want without any pain.
    b. I am able to drive as long as I want with only a mild increase in pain.
    c. Pain prevents me from driving more than 1 hour at a time.
    d. Pain prevents me from driving more than ½ hour at a time.
    e. Pain prevents me from driving more than 15 minutes.
    f. Pain prevents me from driving at all.

9. Social Lifestyle
    a. My social life is normal and gives me no additional pain.
    b. My social life is normal but does increase my level of pain.
    c. Pain does have a limiting restriction on my social activities does not prevent me from going out.
    d. Pain does have a limiting restriction on my social activities and prevents me from going out very often.
    e. Pain has restricted my social life to only home events.
    f. Due to the pain, I do not participate in any of my previous social activities.

10. Exercise
    a. I am able to do any exercise I want without an increase in pain.
    b. I am able to do any exercise with a mild increase in pain.
    c. I am able to exercise but the pain slightly limits my choices.
    d. I am able to exercise but the pain moderately limits my choices.
    e. Due to the pain, my exercise habits have severely been limited.
    f. Due to the pain I am unable to exercise at all.

In the following section please provide 3 short term goals regarding your treatment that you would like to accomplish within the next 60 – 90 days followed by 3 long term goals regarding your treatment that you would like to accomplish by the completion of treatment.

| Short Term Activity/Goal (Next 60 - 90 days): |
|---|
| 1. |
| 2. |
| 3. |
| Long Term Activity/Goal (End of Treatment): |
| 1. |
| 2. |
| 3. |