Auto Accident Information

Patient Name: _____ Date: _____

Accident Information

Accident Date: _____ Time: _____ am/pm
Did the police come to accident site? Yes No
Was a police report filed? Yes, #_____ No
Was a traffic violation issued? Yes No
If yes, to whom? _____
Were there any witnesses? Yes No
Make & Model of the vehicle you were in:
_____
Make & Model of the other vehicle:
_____
Name of the location or street of accident:
_____
In which direction were you going? N S E W
The other vehicle? N S E W
Was your vehicle stopped or moving? _____
If stopped, was your foot on the brake? Y N
If moving, how fast were you going? _____ mph
What was the speed of other vehicle? _____ mph
Did the impact to your vehicle come from the:
Front Rear Driver Side Passenger Side
Did your vehicle strike anything else? Yes No
If yes, please describe: _____
In your words, please describe the accident:
_____
_____
_____
_____
_____

Personal Information

Were you the: Driver Front Passenger
Rear Passenger Other
Were you wearing a seatbelt? Yes No
During the impact which direction were you facing
Forward Right Left
Were you surprised by the impact? Yes No
In relation to the base of your skull, where was the Headrest? Above Below Even
Was your seat reclined? Yes No
Did any part of your body hit anything outside your vehicle? Yes No If yes, describe: _____
_____
Did you have any pain or symptoms immediately after the accident? Yes No If yes, please describe: _____
_____
_____
Did paramedics come to the accident site? Yes No
Did the paramedics examine you? Yes No
Did you go to the hospital? Yes No
Which one? _____
Did you go directly from the accident? Yes No
How did you get there? Ambulance Self Other
At the hospital, what tests were performed?
X Rays _____
CT Scan _____
MRI _____
Other _____
Did you have surgery as a result of your accicent?
If yes, describe: _____

Work Information

What type of work do you do? _____ Where? _____

Please indicate which of the following indicate your daily duties?
Standing Sitting Walking Lifting Driving
Bending Crawling Twisting Typing Stooping
Operate Heavy Equipment or Machinery Work with arms above head Other: _____
Have you missed any work due to the accident? Yes No If yes, how many days? _____
While in recovery, is there any light duty work you can request? Yes No

DOCTOR'S LIEN

TO: Attorney/ Insurance Carrier

_____

_____

Michael Papa DC
2632 Indiantown Rd
Jupiter, Fl 33458

RE:

I do hereby authorize the above doctor to furnish you, my attorney/ insurance carrier, with a full report of his case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/ illness which occurred/ began on _____.

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 such sums as may be due and owing him for services rendered to me, and to withhold such sums from such I do hereby authorize the above doctor to furnish you, my attorney/ insurance carrier, with a full report of his 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 him for services rendered to 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 recover said fees.

Dated: _____ Patient's Signature: _____

Dated: _____ Witness: _____

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 agree to honor the same to protect adequately said above named doctor.

Dated: _____ Authorized Signature: _____

NOTICE: Please date, sign, and copy this form.

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

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 *(PRINT or TYPE)*	Signature	Date

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 *(PRINT or TYPE)*	Signature	Date

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.

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