# PERSONAL INJURY: RECORDS RELEASE

## AUTHORIZATION

Date: _____
Patient Name: _____
Insurance Company: _____
Policy and/or Claim #: _____

I, _____hereby authorize _____
(Patient Name) (Insurance Company)
to release any or all information regarding insurance, accident dates and information, claim and processing information, medical records, lab results including x-ray reports to:

**Vital Health Chiropractic Center | Vital Health of the Palm Beaches**
**411 7th Street #4**
**West Palm Beach, Florida 33401**
**p: 561-835-3556 | f:561-835-0352**

_____
(Patient Signature) (Date)

_____
(Staff Member) (Date)

# PERSONAL INJURY: DETAIL OF ACCIDENT



Name: _____ SS#_____Phone: _____
1.Date of accident: _____ Time of Day: _____AM/PM
2. Road Conditions: Dry Wet Icy Gravel Pavement
Other: _____
3. Were you the: Driver Passenger Front Seat Back Seat
4. What direction were you headed: North South East West
Traveling on _____ (name of Street)
5. Were you struck from: Front Rear Left Side Right Side
6. Were you aware of the impending collision? Yes No
7. Did you lose consciousness (black out)? Yes No
8. Were you wearing a seat belt at the time? Yes No
9. Describe the position of your head rest or back of seat relative to the position of the top of your ears at impact: Above top of ears Below top of ears #of inches above or below top of ears: _____
10. Year, make and model of the vehicle you were in: _____
11. Was the vehicle you were in at the time of impact: Stopped or Moving
If moving, estimate the approximate speed of the vehicle: _____
12. In your own words, please describe the accident:

_____

_____

_____

13. Were the police notified of the accident? Yes No
14. Please describe what happened to you following the accident (i.e. transported to hospital by ambulance, taken to hospital by friend, etc.):

_____

_____

_____

15. Please describe bleeding cuts or bruises received as a result of your accident:

_____

_____

_____

16. Please describe if any of your body parts struck any part of the vehicle. For example, head struck windshield, chest struck steering wheel, chin struck airbag, etc:

_____

_____

_____

17. Was your head pointed straight ahead at time of the accident? Yes No
If no, which direction was it turned and by how much? _____

18. Was your torso pointed straight ahead at the time of the accident?
Yes No If "no", which direction was it turned and by how much?
19. Which of the following vehicle parts broke during the accident:
Windshield Rt/Lft Window Front/Back Seat Steering Wheel
Other: _____
20. What was the cost of damage to the vehicle you were in?
_____

**THE FOLLOWING QUESTIONS PERTAIN TO THE OTHER VEHICLE:**

1. Year, make, model: _____
2. Was the other vehicle moving at the time of the collision? Yes No
If yes, what was the vehicle's approximate speed? _____
3. If the other vehicle was moving at the time of the accident, was it:
Slowing Down Gaining Speed Traveling at a steady speed Don't Know

**HEALTH HISTORY QUESTIONS:**

1. **What are your complaints or symptoms (post accident)?**

_____
_____
_____

2. **Did you have any physical complaints BEFORE THE ACCIDENT?**
**Yes No If yes, please describe in detail:**

_____
_____
_____

3. **Have you received treatment for this injury since the accident?**
**If yes, please list the doctor's name and address and describe the type treatment received:**

_____
_____
_____

4. **If you have been in previous auto accidents or have received treatment for any other significant injuries (other than described above), please list the type of accident or injury and the approximate date below:**

_____
_____
_____

**To the best of my knowledge, the information provided above is true and correct.**

_____

**(Patient Name)** **(Date)**

PERSONAL INJURY
MEDIAL LIEN

I do hereby authorize **Vital Health Chiropractic Center and/or Dr. Mark W. Ashley** to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved.

I do hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered to me both by reason of this accident and by reason of any other bills, including interest on the unpaid balance of my account, that are due his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor.

I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly responsible to said doctor for all medical bills submitted by him 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, judgment, or verdict by which I may eventually recover said fee.

**Date: _____ Patient Name: _____**

**Patient Signature: _____**

The undersigned being attorney of record for the above patient does hereby agree to observe all the sum of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor above named.

**Date: _____ Attorney Name: _____**

**Attorney Signature: _____**

Vital Health Chiropractic Center
411 7th Street #4
West Palm Beach Fl, 33401
p: 561-835-3556 f: 561-835-0352

**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.