Applied Health ASSOCIATES

# MOTOR VEHICLE ACCIDENT HISTORY

| PATIENT NAME: | DATE: |
|---|---|

## ACCIDENT INFORMATION

| DATE OF ACCIDENT: | TIME OF ACCIDENT: | WHERE WERE YOU LOCATED IN THE VEHICLE AT THE TIME OF THE ACCIDENT?<br>❑ DRIVER ❑ PASSENGER FRONT ❑ PASSENGER BACK |
|---|---|---|
| NAME OF DRIVER: | PATIENT VEHICLE (MAKE, YEAR, MODEL): | |
| NAME OF OTHER DRIVER: | OTHER VEHICLE (MAKE, YEAR, MODEL): | |

| LOCATION OF ACCIDENT? | HEAD POSITION?<br>❑ STRAIGHT ❑ RIGHT ❑ LEFT ❑ OTHER _____ |
|---|---|
| HEADREST?<br>❑ NONE ❑ ADJUSTED HIGH ❑ ADJUSTED LOW | SEAT BELT:<br>❑ NONE ❑ NOT WEARING ❑ WEARING |
| AREA OF IMPACT ON YOUR VEHICLE?<br>❑ FRONT ❑ BACK ❑ LEFT SIDE ❑ RIGHT SIDE | AREA OF IMPACT ON OTHER VEHICLE?<br>❑ FRONT ❑ BACK ❑ LEFT SIDE ❑ RIGHT SIDE ❑ N/A |

| WHERE WERE YOU TAKEN AFTER THE ACCIDENT?<br>❑ HOME ❑ DOCTORS OFFICE ❑ HOSPITAL _____ | BY AMBULANCE:<br>❑ YES ❑ NO |
|---|---|
| WHAT WAS DONE FOR YOU?<br>❑ EXAMINATION ❑ X-RAY ❑ MEDICATIONS ❑ OTHER: | OTHER DOCTORS SEEN: |

| POLICE INVESTIGATED?<br>❑ YES ❑ NO | WAS A REPORT FILED?<br>❑ YES ❑ NO | WHICH DEPARTMENT?<br>❑ STATE PATROL ❑ SHERIFF ❑ CITY POLICE |
|---|---|---|
| YOUR VEHICLE WAS MOVING AT WHAT ESTIMATE SPEED?<br>OTHER VEHICLE'S ESTIMATED SPEED? | | AT THE TIME OF THE IMPACT WERE YOU:<br>❑ TOTALLY SUPRISED ❑ BRACED, ANTICIPATING THE IMPACT<br>❑ STOPPED |
| WAS YOUR AIRBAG DEPLOYED?<br>❑ YES ❑ NO | | ROAD CONDITIONS:<br>❑ DRY ❑ WET ❑ ICY ❑ DAMP ❑ OTHER |

## PHYSICAL SYMPTOMS

INITIAL SYMPTOMS: *Check (✓) any/all that apply*

- ❑ NONE
- ❑ HEADACHE
- ❑ NECK PAIN
- ❑ NECK STIFFNESS
- ❑ DIZZINESS
- ❑ MID TO UPPER BACK PAIN
- ❑ LOWER BACK PAIN
- ❑ NERVOUSNESS
- ❑ IRRITABILITY
- ❑ NUMBNESS
- ❑ TINGLING
- ❑ HANDS/ARMS INJURY
- ❑ FEET/LEGS INJURY
- ❑ OTHER _____

LATER SYMPTOMS: *Check (✓) any/all that apply*

- ❑ NONE
- ❑ HEADACHE
- ❑ NECK PAIN
- ❑ NECK STIFFNESS
- ❑ DIZZINESS
- ❑ MID TO UPPER BACK PAIN
- ❑ LOWER BACK PAIN
- ❑ NERVOUSNESS
- ❑ IRRITABILITY
- ❑ NUMBNESS
- ❑ TINGLING
- ❑ HANDS/ARMS INJURY
- ❑ FEET/LEGS INJURY
- ❑ OTHER _____

CURRENT SYMPTOMS:

1303 S. Grand Blvd. Spokane, WA 99202
Phone (509) 838-2225 Fax (509) 755-2225 www.ahaspokane.com

| INSURANCE INFORMATION | |
|---|---|
| PATIENT'S INSURANCE COMPANY NAME: | |
| ADDRESS: | |
| CITY/STATE/ZIP: | PHONE: |
| NAME OF POLICY HOLDER: | |
| ADDRESS: | |
| CITY/STATE/ZIP: | PHONE: |
| POLICY NUMBER: | CLAIM NUMBER: |
| ADJUSTER: | |

| OTHER DRIVER'S INSURANCE INFORMATION | |
|---|---|
| OTHER DRIVER'S INSURANCE COMPANY NAME: | |
| ADDRESS: | |
| CITY/STATE/ZIP: | PHONE: |
| NAME OF POLICY HOLDER: | |
| ADDRESS: | |
| CITY/STATE/ZIP: | PHONE: |
| POLICY NUMBER: | CLAIM NUMBER: |
| ADJUSTER: | |

| OTHER ACCIDENT INFORMATION |
|---|
| HAVE YOU RETAINED AN ATTORNEY? ❑ YES ❑ NO |
| ATTORNEY'S NAME: |
| ATTORNEY'S ADDRESS: |
| ATTORNEY'S PHONE NUMBER: |
| DESCRIBE THE ACCIDENT: |
| USE THIS SPACE FOR ADDITIONAL INFORMATION: |

| SIGNATURE | |
|---|---|
| PATIENT SIGNATURE: | DATE: |

1303 S. Grand Blvd. Spokane, WA 99202
Phone (509) 838-2225 Fax (509) 755-2225 www.ahaspokane.com

**ASSIGNMENT, LIEN, AND AUTHORIZATION**
**FOR DIRECT PAYMENTS BY MY PAYERS TO Applied Healthcare Associates, P.S.**

**Purpose.** The purpose of this Assignment & Lien is to assist the Office in obtaining Proceeds from various Payers for the payment of my Charges. Accordingly, I agree to the following and direct all Payers as follows:

**Definitions.** In this Assignment & Lien, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to Applied Healthcare Associates, P.S., AHA. Located at 1303 S. Grand Blvd. Spokane, WA 99202; "Assignment & Lien Document," "Assignment & Lien," and "Assignment" shall refer to this document. "Payer" shall refer to without limit any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, adjuster, claims handler, medical examiner, individual reviewer or review entity, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds, either now or in the future, or which may be involved directly or indirectly in determining the obligation to pay or disburse Proceeds, either now or in the future; "Proceeds" shall include without limit, the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, the proceeds relating to "health-care-insurance receivables" and "payment intangibles" as such are defined by the applicable Uniform Commercial Code, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare and Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, errors & omissions, and malpractice; "Charges" shall include without limit the full fees for the Office's goods and services (including without limit treatment, diagnostic services, medical equipment, supplies, supplements, narrative reports, photocopies, pre-authorization requests, no-shows, depositions, and testimony, whether rendered before or after the date of this Assignment & Lien), any Collection Costs incurred by the Office, delinquency penalties and interest to the maximum extent permitted under law or at the annual rate of eighteen percent (18%), whichever is greater, and any other charges incurred by me at the Office; "Collection Costs" shall include without limit any pre- and post judgment court costs, filing fees, service of process charges, attorneys fees, fees or costs associated with requests for reconsideration, independent reviews, appeals, mediation, arbitration, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

**Assignment and Lien Terms.** I hereby assign to the Office to the extent permitted by law, but only to the extent of my Charges, all of my claims to, rights to, and interests in, Proceeds, whether resolved or unresolved, including without limit ownership rights, which I may have now or in the future relating directly or indirectly to my Charges, condition, or causes of my condition ("Claims to Proceeds"), including without limit any and all causes of action, receivables, payment intangibles, and remedies that I might have against or with respect to any Payer now or in the future, and the right to prosecute, seek, settle, or otherwise resolve such Claims to Proceeds either in my name or in the Office's name and as the Office otherwise sees fit. I agree that this assignment shall be effective as of the date and time the initial cause of my condition occurred. I further intend for this Assignment & Lien to create a security interest under the applicable Uniform Commercial Code. Accordingly, I hereby grant to the Office a primary, non-contingent security interest in all of my Claims to Proceeds to the extent permitted by law for the purpose of securing payment of my Charges, the attachment and perfection of which shall relate back to, and be effective as of, the date and time that the initial cause of my condition occurred. I further authorize the Office to file the form(s) normally filed with the secretary of state or other governmental agency relating to such security interests, and to make such filings in all relevant jurisdictions as the Office sees fit in its sole discretion. I agree that once payment in-full has been made towards all outstanding Charges to the full extent permitted by law or contract and also as defined by my agreement with the Office, such security interest shall be removed or terminated solely upon my written request sent through the U.S. Postal Service Certified Mail. Consistent with these terms, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, the Office to the full extent of my Charges. To the extent that any law, including without limit a lien statute, purports to limit, reduce, or modify the distribution of Proceeds in any manner inconsistent with this Assignment & Lien including without limit through the reservation of a portion of the Proceeds exclusively to me, I hereby waive such limits, reductions, or modifications. Such waiver shall not adversely affect or prejudice any rights which the Office may have and elect to exercise under said law.

**Specific Direction to Any Attorney I Retain, Such as in Accident Cases.** In the event that I retain one or more attorneys who receive(s) Proceeds from one or more Payers, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding such Proceeds, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office. I agree that the purpose of such Proceeds shall be primarily to pay my Charges. If I have a dispute regarding the Charges, any remedies I may have shall not include instructing my attorney to withhold or delay payment of Proceeds to the Office. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a "Common Fund Doctrine" or other legal basis, to require the Office to absorb the costs associated with, or otherwise assume responsibility for, any portion of my attorney's fees and costs, or other expenses of obtaining Proceeds.

**Disclosure Directives.** I hereby direct each and every Payer to immediately release to the Office any Pertinent Information relating to (a) any coverage I may have and (b) any Proceeds Determination by the Payer relating to the Office's Charges. "Pertinent Information" shall include without limit the amount of total coverage available and remaining, as well as the amount of any outstanding claims which the Payer has received from any claimant relating to my condition. "Pertinent Information" shall also include without limit copies of all documents, records, and other information (a) relied upon by the Payer in making a Proceeds Determination, or (b) was submitted, considered, or generated in the course of making a Proceeds Determination without regard to whether such document, record, or other information was relied upon in making the Proceeds Determination. "Proceeds Determination" shall include without limit any determination by the Payer to pay, deny, or delay payment of any Proceeds relating to the Office's Charges, as well as a decision to refer the Charges to an independent review or audit, utilization review, or independent medical exam. I further authorize and direct the Office to release any information relating any services rendered to or for me by the Office to all Payers, including without limit a copy of my Charges and a copy of this Assignment & Lien, unless otherwise agreed to in writing.

**Miscellaneous.** Except as provided in this paragraph, this Assignment & Lien shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Assignment & Lien. I agree that each and every provision of this Assignment & Lien is reasonably necessary. However, should any provision of this Assignment & Lien be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Assignment & Lien shall, nevertheless, remain in full force and effect. This Assignment & Lien shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Assignment & Lien, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Assignment & Lien.

I have read, understood, and agree to the terms of this Assignment & Lien.

Patient Name (print): _____ Patient Signature: _____ Date: ___/___/____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): _____