STANLICK
chiropractic

Dr. Mitch Stanlick
Dr. Jeremy Bills

Irrevocable Assignment Lien, and Authorization
Insurance Benefits and Attorney

Patient: ___________________________ Insured:___________________________

Claim #: ___________________________ Policy #: ___________________________

Date of Loss: ______________________ Adjuster:__________________________
(____)______________

To whom it may concern:

I hereby authorize and direct you, my insurance company, liability insurance adjuster, and/or my attorney to pay directly to: **Stanlick Chiropractic (Office)** such as may be due and owing to this Office for services rendered to me, both by reason of accident or illness, or any other amounts that are due this office, including but not limited to: interest charges or finance fees and/or collection fees. I authorize and direct you to withhold such sums from any disability benefits, medical payments benefits, no fault benefits, health and accident benefits, workman's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgement or verdict on my behalf as may be necessary to protect said Office. I hereby further give a lien to said Office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgement or verdict which may b paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to act as an assignment of my rights and benefits to the extent of the Office's services provided and any additional fees or charges that may have accrued. This includes but is not limited to, interest fees and collection fees, including reasonable attorney's fees which may be payable as the result of my account being past due.

In the event any insurance company obligated to make payments to me upon charges made by this Office for their services refuses to make such payments, upon demand by me or this Office, I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against such company and authorize this Office to prosecute said cause of action either in my name or in the Office's name and further I authorize this office to compromise, settle, or otherwise resolve said claim or cause of action as they see fit.

I understand and agree that I remain personally responsible for the total amounts due the Office for their services, and any additional fees, including but not limited to interest and collection fees should my account become past due. I further understand that this Assignment Lien and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option. I understand that 1.5% interest per month may be added to any amounts due this Office which are more than thirty days past due, and that said interest charges are protected by this Assignment, Lien and Authorization as are the fees for services provided. I further understand that payment due this Office is not contingent upon any settlement, judgement or verdict by which I may recover said fee. I agree to pay all costs of collection of any balance due this Office, including reasonable attorney's fees.

I authorize this Office to release any information pertinent to my case to any insurance company, adjuster, or attorney or doctor to facilitate collection under this Assignment, Lien and Authorization I agree that the above mentioned Office be given Power of Attorney to endorse/sign my name on any and all checks for payment of amounts due this Office. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her. A photocopy of the Assignment, Lien and Authorization shall be considered as effective and valid as the original. I agree not to rescind or revoke any of the terms of this Assignment, Lien and Authorization, and this document shall be valid from the date I signed it until all amounts due the Office are paid in full.

Signed:_____________________________ Date:________________________
Patient or Responsible Party if Minor

Witness:_____________________________

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

Signed: _____________________________ Date:__________________________

Printed Name:______________________ Address:_____________________

Attorney: Please sign this form, print or type name & address, and return it to:
241 W. Northfield Blvd, Murfreesboro TN 37129 Ph:615-907-7400 Fax:615-907-7435

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_______________

Patient Name_______________

Date of Accident_______________ Time of Accident_______________ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:_______________

Were you the: ☐ Driver ☐ Rear Passenger ☐ Front Passenger ☐ Pedestrian

How many people were in the accident vehicle?_______

ACCIDENT SITE

Road/Street Name_______________

City/State_______________

Nearest intersection with road/street_______________

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _______

Which direction were you headed? _______________

Speed you were traveling?_______________

VEHICLE

Make and model of vehicle you were in:_______________

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

OTHER VEHICLE

(If applicable)

Make and model of other vehicle_______________

Which direction was other vehicle headed?_______________

Speed other vehicle was traveling_______________

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_______________

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_______________

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_______

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right
☐ Looking to the left ☐ Looking down
☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?_______________

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PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?___________

Please describe how you felt immediately after the accident:

____

____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital___________________________ Name of doctor___________________________

Diagnosis____

____

Treatment received____

X-rays taken____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?___________

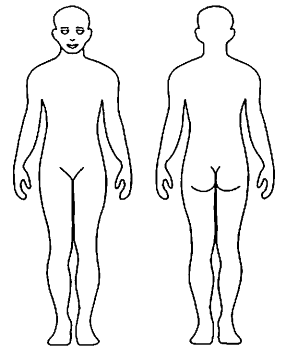
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiff
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Sleep difficulty
☐ Dizziness	☐ Jaw problems	☐ Stomach upset
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other___________

How often do you have this pain?___________________________

Is it constant or does it come and go?___________________________

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

___________________________ Signature of Patient, Parent, Guardian or Personal Representative

___________________________ Date

___________________________ Please print name of Patient, Parent, Guardian or Personal Representative

___________________________ Relationship to Patient

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Dr. Jeremy Bills

Financial Policy for Personal Injury Cases

*It is our office policy that payment for services rendered is ultimately the responsibility of the patient, whether or not you have third party assistance with your financial obligation.

*As a courtesy to our patients, this office will bill third party payers and wait to be paid for some or all of our patients' financial responsibility. This usually means that we have to wait until the patient is released from care to submit all claims at once to the third party insurance (party at fault's insurance). In most cases, the third party will then come to a settlement agreement with the patient and pay the patient directly. After receiving that settlement, the patient is expected to pay their balance in full for the care received at our office.

*If we are filing a Medpay claim through the patient's personal auto insurance, our office will submit claims for services rendered periodically throughout the course of the patient's care. In most cases, the insurance will pay the provider directly, however, occasionally they will send payment to the patient. If this should happen, the patient is expected to remit payment to the provider immediately upon receipt of the payment from the insurance.

*For your convenience, this office accepts cash, check and the following cards:
Visa, Mastercard, American Express, and Discover

*Should payment be refused by your bank for any check written, this office will charge a fee of $25 to offset the charges we will incur as a result of the returned check.

Signed: ______________________________________ Date:__________________

Witness: _____________________________________ Date: __________________

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