# Cura Integrative Health Care

## Automobile Accident Questionnaire

Client Name: _____ DOB: _____

Accident Details: How did this accident happen?

_____

_____

Driver of Vehicle: _____ Accident Date & Time: _____

Insurance Company: _____ Phone Number: _____

Policy Number: _____ Claim Number: _____

Name of Driver of other Vehicle: _____

Insurance Company: _____ Phone Number: _____

Policy Number: _____ Claim Number: _____

Location of Accident: _____

Number of People in your vehicle: _____ Police Called? Y / N Injured? Y / N

You were: Driver Passenger Front seat Back seat Using the seat belt

Saw the accident/car coming Hit air bag/windshield on impact (circle all that apply)

Injuries: _____

Were you knocked unconscious? Y / N If so, how long? _____

Immediate Pain after accident? Y / N If so, Location of Pain: _____

Were you transported to the hospital? Y / N If so, how? _____

Any problem in injured area prior to the accident? _____

Did you receive any health care after the accident? _____

Treatment given: _____

Doctor Attending: _____ Diagnosis: _____

Injury resulting in permanent disability? _____

Is work restricted as a result of this accident? Y / N If so, how? _____

_____

Patient Signature: _____ Date: _____

Cura Integrative HEALTH CARE

# THIRD PARTY MEDICAL LIEN AND ASSIGNMENT

PATIENT:_____
CLAIM#_____
DATE OF INJURY:_____

I hereby authorize and direct_____Insurance Company to pay to Dr. Jill Strom, DC, such sums as may be due and owing her 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 said doctor. And I hereby further request that payment be made directly to said doctor which would otherwise be paid to myself, as the result of the treatment charges injured for injuries in connection therewith. This is a direct assignment of my rights and benefits under contract.

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

Please acknowledge your agreement to this request by signing below and returning to the doctor's office below. I have been advised that if you do not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but may declare the entire balance due and payable by me.

DATE:_____
PATIENT SIGNATURE:_____

The undersigned Insurance company does hereby agree to ovserve all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect and fully compensate said doctor above and below named and make payment payable directly to said doctor.

DATE:_____
Signature of Insurance Company Representative:_____
Print First and Last Name:_____
Insurance Company Name:_____

Please date, sign and returned one copy to the doctor's office below.

Cura Integrative Health Care
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