PERSONAL INJURY/AUTOMOBILE ACCIDENT FINANCIAL POLICY

Our Personal Injury/Automobile Insurance Assignment Program is designed to render you immediate care and keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your insurance carrier on your behalf and wait up to six months for payment. Please remember, however, that you are ultimately responsible for payment of all services rendered to you regardless of insurance coverage or settlement status. Termination of care prior to your doctor's release will result in all balances being due immediately. Please notify us if you are using an attorney. Listed below are payment options for your personal injury claim.

MEDICAL PAYMENTS

"Medical Payments" or "Med-Pay" is part of your own auto insurance policy which will immediately cover the costs of your medical expenses given by a licensed health care provider and those of any passengers in your car, up to a certain limit, regardless of fault. This will allow you to get the treatment you need for your injuries without the hassle of dealing with the other party's insurance company. Med-Pay is primary for services rendered to personal injury patients when available.

HEALTH INSURANCE

Your Group or Individual Health Insurance may cover your medical expenses resulting from injuries sustained in an automobile accident. If coverage is available, your health insurance company may seek reimbursement for payments made from the third party. We will assist you in verifying your coverage. You will be responsible for any co-payments or deductibles that your policy requires. In certain instances, we may be able to wait for payment for co-pays and deductibles until a settlement is reached with the third party.

THIRD PARTY

Arizona operates under a traditional "fault" auto insurance model, which means that drivers involved in Arizona car accidents have several options. They may file a claim with their own auto insurance company, file a claim with the at-fault driver's auto insurance company, or file a personal injury lawsuit in court seeking damages from the at-fault driver.

SELF PAY

You also have the option of paying at the time of service for your care and seeking reimbursement from the responsible party/insurance carrier yourself. If you prefer to do this, we will provide itemized statements along with detailed records and reports upon request.

All financial and claim documents must be completed prior to the second visit or no treatment can be rendered.

I have read and understand the personal injury/automobile accident financial policy of InMotion Health & Wellness. I understand that I am ultimately responsible for any services rendered to me in this office. Payment for services is not contingent upon my insurance coverage or settlement with a third party. I understand that if I terminate care outside my doctor's recommendations, any balances will be due immediately.

______________________________________ ____/____/____

Patient Signature

PERSONAL INJURY / AUTOMOBILE ACCIDENT DETAIL FORM

Patient Name: ______________________________ Today's Date: _____/_____/_____

Date of Accident: ____/____/____

AUTO INJURY

Were You: ( ) Driver ( ) Passenger ( ) Pedestrian

Were you struck from :( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked

Were there other passengers/drivers in your vehicle: ( ) Yes ( ) No

Did your car strike the others involved :( ) Yes ( ) No ( ) Undetermined

Did the other car strike yours: ( ) Yes ( ) No ( ) Undetermined

As a result of the Accident, were traffic citations issued to you? ( ) Yes ( ) No Explanation of Accident:

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____

ON-THE-JOB INJURY- how did the injury occur?

____

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____

Did you report the injury to your employer: ( ) Yes ( ) No

Employer:____

Address:____

OTHER ACCIDENTAL INJURY Describe the circumstances of the accident (Be Specific)

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CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

__ Headache __Sleeping Problems __ Light Sensitivity __ Diarrhea __ Neck Pain __ Head too heavy
__ Memory Loss __Cold Feet __ Stiff Neck __ Pins & Needles __ Ears Ringing __ Cold Hands
__ Dizziness __ Face Flushed __ Upset Stomach __ Back Pain __ Numb Fingers __ Buzzing Ears
__ Constipation __ Nervousness __ Numb toes __ Loss of Balance __ Cold Sweats __ Tension
__ Short Breath __ Fainting __ Loss of Smell __ Chest Pain __ Depression __ Other

Have you had any other treatment for this accident? ( ) Yes ( ) No

Have you lost any days of work? ( ) Yes ( ) No If Yes, ___/___/____ through ___/___/____

Patient / Guardian Signature: ______________________________

PERSONAL INJURY / AUTOMOBILE ACCIDENT CLAIM INFORMATION FORM

Patient Name: ________________________________ Today's Date: _____/_____/_____

YOUR AUTO INSURANCE POLICY

Name of Company:____
Telephone #:____
Name on Policy: ____
Policy #:____
Claim #:____
Claims Representative Name and Telephone #:____
Do you have Medical Payments Benefits on your policy? ( ) Yes, Amount:$________ ( ) No ( ) I don't know

THIRD PARTY INSURANCE POLICY

Third Party's Name:____
Name of Company:____
Telephone #:____
Name on Policy: ____
Policy #:____
Claim #:____
Claims Representative Name and Telephone #:____

Please provide your group or individual health insurance information on the initial intake forms.

Patient / Guardian Signature: ________________________________

ATTORNEY (If applicable)

Name:____
Lawfirm:____
Telephone #:____

ASSIGNMENT OF BENEFITS

I hereby assign all healthcare benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including automobile insurance, private health insurance, third party insurance, and any other health/ medical plan, to issue payment check(s) directly to InMotion Health & Wellness for medical services rendered to myself and/or my dependents regardless of my insurance benefits. I understand that I am ultimately responsible for any amount not covered by my insurance or any third party. I understand that this assignment given to InMotion Health & Wellness herein is irrevocable.

______________________________________ ____/____/____

Patient's / Guardian's Signature Date

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize InMotion Health & Wellness to: (1) release any information necessary to insurance carriers regarding my injuries and treatments; (2) process insurance claims generated in the course of examination or treatment. This order will remain in effect until revoked by me in writing.

______________________________________ ____/____/____

Patient's / Guardian's Signature Date

____________________________________ ____/____/____

Office Staff/ Manager Signature

LIEN FOR INMOTION HEALTH & WELLNESS

To:

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RE: Medical Records and Doctor's Lien

I do hereby authorize InMotion Health & Wellness to furnish you, my attorney/insurance carrier, with a full report of their case history, examination, diagnosis, prognosis and service of/to myself in regard to my accident/illness which occurred/began on ________________.

I hereby give a lien to InMotion Health & Wellness 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 InMotion Health & Wellness such sum as may be due and owing them for services rendered me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to pay InMotion Health & Wellness adequately.

Please acknowledge this letter by signing below and returning it to the doctor's office.

I fully understand that I am directly and fully responsible to InMotion Health & Wellness for all bills submitted by them for services rendered to me, and that this agreement is made solely for InMotion Health & Wellness' additional protection and in consideration of their awaiting payment.

Dated ____________________ Patient Signature ____________________________________

The undersigned attorney of record for the above patient does hereby agree to observe all of the above terms and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above named. Attorney further agrees that in the event this lien is litigated, the prevailing party will be awarded attorney's fees and cost.

Dated ____________________ Attorney's Signature ____________________________________

Please date and sign and return to doctor's office.