Peters Wellness Chiropractic, Inc.

1616 North Litchfield Road, #100
Goodyear, Arizona 85395
(623) 935-0911 • (623) 935-0921/fax

Lien Information

1. Your Patient's Name: _____

2. Your Patient's Address: _____

   City: _____ State: _____ Zip Code: _____

3. Date of Accident: _____

4. Place of Accident: _____ County or City: _____

5. Your Patient's **Auto** Insurance: (**List Only If Benefits Are Available**)
   Insurance Company: _____
   Address: _____
   Policy Number: _____ Claim Number: _____

6. If this Accident was caused by a third party:
   (If Known-NOT REQUIRED) That Person's Name: _____
   Address: _____
   City: _____ State: _____ Zip: _____
   Required That Person's Insurance Company: _____

   Address: _____

   City: _____ State: _____ Zip: _____

   Policy Number: _____ Claim Number: _____

7. Other Insurance (driver, vehicle owner, or any insurance related to this accident)
   _____
   _____

(Health Care Provider Needs to Fill Out Information Below)

8. Is the patient still being treated? _____ yes _____ no (check one)

   a. Date(s) Services Rendered: _____

   b. Amount Due on Account: $_____

Fax Lien Information Form to:
AZ - MEDLIEN
FAX (602) 467-9642

Peters Wellness Chiropractic, Inc.

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Goodyear, Arizona 85395
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PATIENT FINANCIAL AGREEMENT

(Equitable Lien/Benefit Assignment Contract and Indemnification Agreement)

Please read the following very carefully as it concerns your financial responsibility to the Health Care or Service Provider from whom you are about to receive services.

I _____ ***[patient printed name],*** the undersigned Patient hereby agrees to establish a Lien/Assignment of benefits or claims in favor of **Peters Wellness Chiropractic, Inc.** by this contract and pursuant to any state statutes that apply in the state where I reside and/or are receiving treatment. I give my permission for **Peters Wellness Chiropractic, Inc.** and/or their agent, to file, record and serve notice of a copy of a recorded copy of a *Notice and Claim of Statutory Health Care Provider Lien Equitable Lien/Benefit Assignment Contract and Indemnification Agreement* upon all parties who may be liable, including me for damages arising from the accident which occurred on _____ ***[d a t e]*** and any subsequent claims arising from this accident for which I am receiving health care services. I understand that by doing so I am willingly signing a contract with the above named health care or service provider. **I am authorizing direct payment(s) to Peters Wellness Chiropractic, Inc. from any and all proceeds regardless of which insurance policy makes payment, settlement, compromise, judgment verdict or damages** to which I may be entitled and paid in connection with the settlement of claims or litigation arising from this accident, in such sums necessary **to fully compensate the health care or service provider from whom I have received care.** The Lien/Assignment created by this Equitable Lien Contract and Indemnification Agreement shall have priority over any subsequent liens or assignments of my interests in claims arising from this accident.

In exchange for providing the necessary medical care without requiring payment in full at the time services are received, I agree that I am responsible for all charges associated with my care, regardless of the insurance companies' reimbursement, settlement or compromise. Charges for which I agree to be responsible for, include all administrative expenses associated with processing my claim, including recording and/or serving the notice of this Lien/Assignment upon all liable parties and/or their insurance companies.

I _____ ***[patient printed name],*** *authorize my auto insurance company, any liable insurance company or attorney's office to release any information requested by* **Peters Wellness Chiropractic, Inc.** *pertaining to my personal injury accident.*

Also included will be any collection charges or legal costs and fees incurred while attempting to collect any missing accident information and/or medical bills related to this claim should such measures become necessary.

_____ _____

Patient's signature Date

_____

[If patient is a minor print minor's name here]

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type

☐ Car ☐ Station Wagon
☐ Van ☐ Pickup Truck
☐ Large Truck ☐ Bus
Other_____

2. Your position in vehicle

☐ Driver ☐ Front Passenger
☐ Left Rear Passenger
☐ Right Rear Passenger
Other_____

3. What was your vehicle doing at the time of the accident?

☐ Stopped at intersection ☐ Stopped in traffic ☐ Stopped at light
☐ Making a right turn ☐ Making a left turn ☐ Parking
☐ Proceeding along ☐ Slowing down ☐ Accelerating
Other_____

4. Time/Speed/Damage

Time of accident_____
Your vehicle's speed: _____mph
Their vehicle's speed: _____mph
Damage to your vehicle
☐ Mild ☐ Moderate
☐ Totaled

5. Details of Accident

Visibility at time of accident
☐ Poor ☐ Fair ☐ Good

Who hit who/what?
☐ You hit other vehicle
☐ Other vehicle hit you
You hit...(object)
_____

6. Road conditions

Road conditions at time of accident
☐ Icy ☐ Wet ☐ Sandy ☐ Dark ☐ Clean and dry

Point of impact
☐ Head-On ☐ Left Front ☐ Right Front
☐ Read-End ☐ Left Rear ☐ Right Rear

7. Body Position, etc.

Did you see the accident coming: Yes☐ ☐ No
Were you braced for the impact? Yes☐ ☐ No
Did you have a seat belt on? Yes☐ ☐ No
Did you have a shoulder harness on? Yes☐ ☐ No

Does your vehicle have headrests? Yes☐ ☐ No
What was the position of your headrest at the time of the impact?
☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck
What was the direction of your head at the time of the impact?
☐ Facing straight forward ☐ Turned to the right ☐ Turned to the left

Did driver side air bags deploy? Yes☐ ☐ No Did passenger side airbags deploy? Yes☐ ☐ No Did side airbags deploy? Yes☐ ☐ No

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident:

Did your body strike the inside of your vehicle? Yes☐ ☐ No
If yes, describe:_____
Did you lose consciousness during the injury? Yes☐ ☐ No
If yes, for how long?_____
Your vehicle's estimated damage?_____
Damage to their vehicle: ☐ Mild ☐ Moderate ☐ Totaled
Did police show up at the scene? Yes☐ ☐ No
Was an accident report filled out? Yes☐ ☐ No

10. After the accident:

Check off your symptoms right after and a few days following:

☐ Headache	☐ Dizziness	☐ Mid back pain	☐ Cold hands
☐ Neck pain	☐ Nausea	☐ Low back pain	☐ Cold feet
☐ Neck stiffnes	☐ Confusion	☐ Nervousness	☐ Diarrhea
☐ Fainting	☐ Fatigue	☐ Loss of taste	☐ Depression
☐ Ringing in ears	☐ Tension	☐ Toe numbness	☐ Anxious
☐ Loss of smell	☐ Irritability	☐ Constipation	☐ Chest Pain
☐ Pain behind eyes	☐ Shortness of breath	☐ Sleeping problems	

Others:_____

11. Emergency Room?

Where did you go after the accident?
☐ Home ☐ Work ☐ Hospital ER ☐ Private Doctor
How did you get there?
☐ Drove self ☐ Somebody else ☐ Ambulance ☐ Police
Were X-rays done? Yes☐ ☐ No Was lab work done? Yes☐ ☐ No
Body parts X-rayed?_____
What lab work?_____
The X-rays revealed:_____
Treatments: ☐ Cervical Collar ☐ Ice Other:_____
Medications:_____
Follow-up instructions:_____
_____

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office.
1. Dr._____ First visit date: ___/___/___
Specialty:_____ X-rays done? Yes☐ ☐ No
Types of treatments received:_____
How many treatments received? ____ Currently treating? Yes☐ ☐ No
Did treatments benefit you? Yes☐ ☐ No
Last visit date: ___/___/___
2. Dr._____ First visit date: ___/___/___
Types of treatments received:_____
How many treatments received? ____ Currently treating: Yes☐ ☐ No
Did treatments benefit you? Yes☐ ☐ No
Last visit date: ___/___/___

Peters Wellness Chiropractic, Inc.

Disclosure of Fees

99203-25	Problem Focused Examination	$160.00
99213-25	Expanded Problem Focused – Re-Exam	$60.00
98940	Spinal Adjustment 1-2 Regions	$45.00
98941	Spinal Adjustment 3-4 Regions	$69.00
98943-59	Extremity Adjustment (one or more)	$51.00
97110	Therapeutic exercises	$52.00
97010	Cryotherapy	$15.00
97012	Mechanical Traction	$30.00
97014	Electrical Stim	$45.00
97140-59	Manual Therapy	$53.00
97530	Therapeutic Procedures	$50.00

I have read the above codes and fees and understand the cost of my care at Peters Wellness Chiropractic, Inc. I understand that I am responsible for payment of all deductibles and copayments related to my care. I understand that if I have a balance for medical services not paid, I will make a minimum payment of $50.00 each month or 25% of the outstanding balance whichever is greater. If my balance is not paid in a timely and monthly fashion, I promise to pay any and all collection, court, and attorney fees in the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the above fee schedule regardless of the outcome of my case. I understand that if a check or debit is returned for insufficient funds, I will be charged a $25.00 service charge.

I have read and fully understand the above financial terms and prices. Furthermore, with my signature, I authorize my treating doctor or assign to pursue collection via small claims court or higher court of law to assist me in collection of any outstanding bill.

Signed: _____ Date: _____