# Motor Vehicle Accident Information

| | |
|---|---|
| Last Name: | Social Security no.: |
| First Name: | Middle: |

**General Information**

| | | | |
|---|---|---|---|
| **Date of Accident:** | | | |
| **Location** (circle one) | **Driver** | | |
| | **Passenger** | Location (circle one) | Front / Middle / Rear |
| | | Position (circle one) | Left / Middle / Right |

**Work from Left to Right and Circle One**

| | | |
|---|---|---|
| **Patients Vehicle** | **Type :** | Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other: |
| | **Size :** | Mini / Sub Comp / compact / Mid Size / Full Size |
| | **Action :** | Stopped / Slowing / Acceleration / Cruising |
| | **Speed : (**MPH**)** | |
| | **Time of Accident:** | Day Light / Dawn / Dusk / Dark |
| | **Road Condition :** | Dry / Damp / Wet / Snow / Ice |
| | **Visibility :** | Good / Fair / Poor |

*Enter impact Information for up to three Vehicles or Objects*

**Impact Information: Vehicle or Object (I)**

| | | |
|---|---|---|
| (Select one) | **Name Object :** | |
| ☐ **Vehicle** | **Vehicle Type :** | Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other: |
| | **Size :** | Mini / Sub Comp / compact / Mid Size / Full Size |
| ☐ **Object** | **Damage to Veh.:** | Minimal / Moderate / Extensive / Totaled / Unsure |
| **Impact Location** | | |

**Impact Information: Vehicle or Object (II)**

| | | |
|---|---|---|
| (Select one) | **Name Object :** | |
| ☐ **Vehicle** | **Vehicle Type :** | Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other: |
| | **Size :** | Mini / Sub Comp / compact / Mid Size / Full Size |
| ☐ **Object** | **Damage to Veh.:** | Minimal / Moderate / Extensive / Totaled / Unsure |
| **Impact Location** | | |

**Impact Information: Vehicle or Object (III)**

| | | |
|---|---|---|
| (Select one) | **Name Object :** | |
| ☐ **Vehicle** | **Vehicle Type :** | Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other: |
| | **Size :** | Mini / Sub Comp / compact / Mid Size / Full Size |
| ☐ **Object** | **Damage to Veh.:** | Minimal / Moderate / Extensive / Totaled / Unsure |
| **Impact Location** | | |

## During Impact Information:

| | | | | | |
|---|---|---|---|---|---|
| Seat Belt? | ☐ Yes | ☐ No | Brakes Applied ? | ☐ Yes | ☐ No |
| Air Bag Deployed? | ☐ Yes | ☐ No | Seat Broken ? | ☐ Yes | ☐ No |
| Seat Back position Changed? | ☐ Yes | ☐ No | | | |

| | |
|---|---|
| Head Rest : (Circle one) | Low / Mid / High / None |
| Prepare for Accident: (Circle One) | Un-expected / Expected / Expected and Braced |
| Body Position : (Circle one) | Straight / Rotated Left / Rotated Right / Unsure / Other: |
| Body Thrown? | ☐ Yes / ☐ No |
| Direction of Throw :(Circle One) | Backwards / Forward / Outside / Unsure / Other: |

(Circle One)

| | |
|---|---|
| Head Position : | Straight / Rotated Left / Rotated Right / Forward / Unsure / Other: |
| Head Motion : | Forward Backwards / Backwards Forward / Right Left / Left Right / Unsure / Other: |

**Body Impact** (Indicate any parts of your body that were struck during the impact)

| | | | |
|---|---|---|---|
| ☐ Head | ☐ Upper Back | ☐ Right hand | ☐ Lower Back |
| ☐ Left Shoulder | ☐ Left Leg | ☐ Mid Torso | ☐ Right Foot |
| ☐ Left Arm | ☐ Right Leg | ☐ Mid Back | ☐ Left Foot |
| ☐ Left Elbow | ☐ Right Shoulder | ☐ Right Knee | ☐ Other : |
| ☐ Left hand | ☐ Right Arm | ☐ Left Knee | |
| ☐ Upper Front Torso | ☐ Right Elbow | ☐ Lower Front Torso | |

## After Accident Information:

| | |
|---|---|
| **Im**mediately After Accident: | ☐ Dizzy/dazed ☐ Upset ☐ Weak ☐ Nervous ☐ Headache ☐ Disoriented ☐ Unconscious ☐/Other: |

**Pain** (Indicate if you experienced any pain immediately following the accident)

| | | | |
|---|---|---|---|
| ☐ Head | ☐ Left foot | ☐ Right foot | ☐ Left Knee |
| ☐ Left Hand | ☐ Left Shoulder | ☐ Right Shoulder | ☐ Right knee |
| ☐ Right Arm | ☐ Left Elbow | ☐ Left Arm | ☐ Other : |
| ☐ Upper Front Torso | ☐ Mid Torso | ☐ Right elbow | |
| ☐ Upper Back | ☐ Mid back | ☐ Lower Front Torso | |
| ☐ Left Leg | ☐ Right Leg | ☐ Lower Back | |

| | |
|---|---|
| **Numbness**: | ☐Left Hand ☐ Right Hand ☐ Left Leg ☐ Right Leg ☐ Left Upper Arm ☐ Right Upper Arm ☐ Left Foot ☐ Right Foot ☐ Other: |

**Medical Information** (Did you get medical care for this accident before coming to our office)

| | | |
|---|---|---|
| Medical Care? | ☐ Yes | ☐ No |

| | |
|---|---|
| Time of care | Next day / At time of Accident / Later that Day / Days Later: (Specify) |
| Transported | Drove Self / Ambulance / Other |
| Went To | Orthopedic / Chiropractor / Neurologist / Family Doc / ER / Other:(Specify) |
| Admitted to Hospital? | ☐ Yes ☐ No Days Spent in Hospita: |
| Test: | ☐ X-ray ☐ Lab Work ☐ MRI ☐ CT Scan ☐ Other:(Specify) |
| Treatment: | ☐ Ice Pack ☐ Hot Pack ☐ None ☐ Cervical Collar ☐ Medication ☐ Other:(Specify) |

## Previous Injuries

| | |
|---|---|
| Previous Injuries / Accidents | ☐ No ☐ Yes, Specify: |
| Residual pain from Previous Injuries/Accidents | ☐ No ☐ Yes, Specify: |

## Later Symptoms (Please note any symptoms that started after the accident occurred)

| | |
|---|---|
| Head | ☐ Headache ☐ Dizziness ☐ Blurred Vision ☐ Light Headedness ☐ Loss of Vision<br>☐ Fainting ☐ Loss of Memory ☐ Pain in ear ☐ Double Vision<br>☐ Other Specify: |
| Neck (with Movement) | ☐ Pain in Neck ☐ Forward ☐ Backward ☐ Turn Left ☐ Popping in Neck<br>☐ Muscle Spasms ☐ Turn Right ☐ Bend Left ☐ bend Right<br>☐ Other Specify: |
| Shoulders | ☐ Pain in Shoulder joint ☐ Tension in shoulders ☐ Muscle Spasms in Shoulder<br>☐ Pain across shoulder ☐ Cant raise arms above [ ] Above shoulder level [ ] Over head<br>☐ Other Specify: |
| Arms and Hands | ☐ Pain in Fingers ☐ Numbness in Left Arm ☐ Hands Cold<br>☐ Pin & needles in hands ☐ Numbness in Right Arm ☐ Loss of Grip Strength<br>☐ Pin & needles in fingers ☐ Swollen joints in Fingers<br>☐ Other Specify: |
| Chest | ☐ Chest pain ☐ Pain Around Ribs ☐ Shortness of Breadth ☐ Breast Pain<br>☐ Other Specify: |
| Abdomen | ☐ Nervous Stomach ☐ Nausea ☐ Diarrhea ☐ Gas ☐ Constipation<br>☐ Other Specify: |
| Mid back | ☐ Sharp Stabbing ☐ Mid pain back ☐ Pain From front to back ☐ Dull Ache<br>☐ Pain in Kidney Area ☐ Muscle Spasms ☐ Pain between shoulders<br>☐ Other Specify: |
| Lower Back | ☐ Low Back Pain<br><br>Low back pain is worse when<br>☐ Working ☐ Lifting ☐ Stooping ☐ Standing<br>☐ Sitting ☐ Bending ☐ Coughing ☐ Lying Down ☐ Muscle Spasms<br><br>☐ Other Specify: |
| Hips, Legs & Feet | ☐ Pain in Buttocks ☐ Pain and needles in Legs ☐ Pain down leg<br>☐ Pain in hip joint ☐ Feet feel Cold ☐ Swollen Feet<br>☐ Numbness in Toes ☐ Numbness of Leg ☐ Knee pain<br>☐ Leg cramps ☐ Cramps in Feet<br><br>☐ Other Specify: |
| General | ☐ Nervousness ☐ Fatigue<br>☐ Irritable ☐ Depressed<br>☐ Generally Feel Rundown ☐ Prostate Pain/Swelling<br>☐ Difficulty Urinating ☐ Night Urination<br>☐ Cramping ☐ Irregularity<br><br>Loss of Sleep : [_____] hrs per night<br><br>Loss of weight : [_____]lbs<br><br>Gain weight : [_____] ibs<br><br>Other: |

Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

# IRREVOCABLE ASSIGNMENT AND CONVEYANCE OF LIEN INTEREST IN INSURANCE PROCEEDS, GRANT OF POWER OF ATTORNEY AND PAYMENT AGREEMENT

**THIS IRREVOCABLE, NON-RESCINDABLE, ASSIGNMENT AND CONVEYANCE OF LIEN INTEREST IN INSURANCE PROCEEDS** is entered this date by and between the undersigned Health Care Recipient, hereinafter called "Patient", and **Frederic Taylor, D.C. d/b/a Taylor Family Chiropractic, 909 Main Street, Bastrop, Texas 78602**, hereinafter called "Provider".

**WHEREAS**, Patient desires to receive health care services from Provider and requests that Provider provide such services, but defer payment on the part of Patient for such services until Patient secures his/her insurance settlement proceeds. In consideration of Provider's willingness to agree to such terms and in accordance with the provisions of Tex. Ins. Code, Title 8, Subtitle A, Chapter 1204, §1204.053(a) [entitled "Assignment of Benefits"], Patient does hereby: (i) waive any obligation on the part of the Provider under Tex. Civ. Pract. & Rem. Code Ann., §146.002(b), and (ii) irrevocably assign and convey the following lien interests, rights and benefits to Provider as the legal consideration and inducement to cause Provider to forego its legal right to require payment upon provision of services and wait for the payment of such benefits from Patient or Patient's representative. It is hereby agreed:

**SECTION 1.** Patient hereby irrevocably acknowledges full financial responsibility for all services provided to patient by Provider as consideration for such Provider services. Patient irrevocably assigns and conveys a lien interest to Provider in all benefits to which Patient has, may have, or may maintain a legal entitlement to receive in the form of future monetary proceeds due to be paid by or from any liability or health insurance plan(s), including PIP statutory insurance benefits, that are maintained by Patient or under which Patient derives some legal entitlement, as consideration for all health care services provided by Provider to Patent, up to the total amount of all unpaid charges for such Provider services. Patient irrevocably conveys and assigns to Provider such lien interest lien on any proceeds he/she is entitled to receive from any insurer, including his/her PIP insurance benefits up to the dollar amount of any unpaid charges owed by Patient to Provider. Such conveyance of lien interest shall be deemed hereunder to apply to: (i) any and all benefits, claims and/or monetary proceeds to which Patient may be or become entitled to receive, payable by or from any automobile medical or PIP insurance coverage maintained by Patient or any person under whose policy of insurance Patient may have a lawful right of recovery, (ii) any and all benefits, claims and/or monetary proceeds to which Patient may be or become entitled to receive, payable by or under any third party liability insurance coverage as a result of any claim for damages to which Patient may have a right of recovery, and (iii) a "common law lien interest" in, and all contractual rights and claims to, any and all insurance proceeds to which Patient has or maintains a legal entitlement, to be paid by or from any insurance company, health care benefit plan, or any other party contractually liable for payment of all or any portion of the charges for health care services rendered by Provider to the Patient as a result of the injuries sustained by Patient. This irrevocable conveyance and assignment of lien interest and conveyance and assignment of contractual rights to and for those charges attributable to Provider's health care services shall extend to, but not be limited to, Provider's entitlement to any and all claims to insurance proceeds payable as a result of any insurance coverage for damages borne by the Patient which has given rise to the above referenced health care services provider by Provider.

This irrevocable assignment and conveyance of lien interest shall extend to the total amount of charges incurred by Patient for those services rendered by Provider. Patient agrees that full payment for all services rendered by Provider is due upon receipt of said services and Patient accepts full financial responsibility for payment for such services. Patient acknowledges that Patient is ultimately financially responsible for the payment of all services that Patient receives from Provider regardless whether any portion of those fees and charges due to be paid by Patient to Provider are paid through insurance proceeds to which Patient has asserted a claim. Patient acknowledges that Provider's acceptance of Patient's irrevocable assignment of benefits and lien interest is a convenience to Patient, and that Provider may revoke this assignment and lien interest at any time.

**SECTION 2.** Patient hereby grants and conveys Provider this irrevocable lien interest against any and all monetary proceeds to which Patient may or have a legal claim against the party or parties that gave rise to Patient's claims for damages for which Provider has been engaged to provide healthcare services and any entitlement to insurance and/or health care payment proceeds due to be paid to Patient as a result of any claim Patient has or may have against any party whose negligence may have caused Patient's injuries or illnesses for which Patient has asserted Patient's pending insurance claim. Patient hereby grants this irrevocable lien interest against all such insurance or health care proceeds to which Patient is, or may become, entitled, including, but not limited to, all proceeds due to be paid on Patient's behalf out of any Medical Payment or statutory Personal Injury Protection insurance coverage, as a result of those services rendered to Patient by Provider. Said lien interests shall not exceed the total amount of expenses and debt obligations incurred, and due to be paid, by Patient to Provider for such services rendered.

_____ _____

Date **Patient Signature**

**SECTION 3.** Patient hereby irrevocably directs all insurers, health care plans, legal counsel, and other persons or parties responsible for the payment, co-payment or other obligation for Patient's health care costs arising from injuries sustained by Patient for which the above referenced services have been provided by Provider, to remit and/or make all monetary payments remitted as consideration, in whole or in part, for those health care services rendered by Provider for and on behalf of Patient, directly to Provider. Patient further directs that any lawyer or representative employed by Patient to represent Patient in any action for which the above referenced services have been rendered by Provider, insurer or third party, shall be, and is hereby, irrevocably instructed and required to withhold from any monetary distribution to Patient, Patient's lawyer and/or any other person or party asserting any monetary interest against any proceeds to which Patient may awarded, the full amount of Patient's outstanding and unpaid account due and owing to Provider out of any private party settlement proceeds, insurance settlement proceeds of whatever nature (liability, PIP, etc.), and /or any court verdict and remit payment of the dollar amount of Patient's unpaid and outstanding account with Provider, directly to Provider immediately upon receipt of same. This directive made by the Patient to the Patient's lawyer is to be deemed irrevocable and non-rescindable and shall extend to and include any PIP or medical payment benefits recovered by or on the Patient's behalf of the Patient or Patient's lawyer.

**SECTION 4.** Patient willfully and voluntarily makes and appoints Provider, through its duly appointed representative of the City of Austin, Travis County, Texas, as Patient's lawful Attorney-in-Fact for purposes of receiving and directing disbursement of those payments of insurance or settlement proceeds to be paid to Patient, or on Patient's behalf, as compensation for those for the health care services rendered by Provider, and the resultant payment obligations owed by Patient to Provider as a result of same. Patient hereby delegates and conveys to Provider those rights and powers of substitution on Patient's behalf, to ask, demand, sue for, collect, endorse, sign, and receive such monetary proceeds, in Patient's name, to PIP insurance, other health benefits, and third party claims relating to services rendered to Patient by Provider. Although Provider is granted such special powers contained herein, Provider is not obligated or compelled to exercise such powers but may do so at Provider's discretion. Patient agrees to cooperate with Provider to request and receive from any insurer, employer, or other third party payor any and all information or supporting documentation concerning or touching upon the handling, calculation, processing, or payment of any claims arising from services rendered to Patient by Provider.

**SECTION 5.** To the extent that Patient has lawful authority, Patient waives any applicable statute of limitations that may at any time interfere with Provider's right to collect for services rendered to Patient. Patient agrees that in the event Patient or Patient's authorized representative, including legal counsel, receives any check, draft, or other payment subject to this Agreement, Patient and Patient's authorized representative shall be deemed to serve in a fiduciary capacity to Provider, for the benefit of Provider, with full obligation to immediately deliver said check(s), draft(s), or payment(s) to Provider. Provider agrees to apply the proceeds from said check(s), draft(s), or payment(s) to Patient's debt for services rendered.

**SECTION 6.** Patient hereby irrevocable consents to, and authorizes, his lawyer/legal counsel to release to Provider, upon request by Provider, any and all records or documentation pertaining to Provider's insurance claims, legal claims, pending causes of action, or otherwise pertaining to the expense or charge for any service rendered by Provider for Patient's benefit.

**SECTION 7.** Patient irrevocably agrees and consents to Provider's submission of a copy of this Agreement and any other claim for payment of insurance proceeds to any and all insurance carrier(s) against whom Patient is, or may, assert or maintain any claim for damages and reimbursement for the cost for those services provided by Provider, including, but not limited to, any insurance coverage for Medical Payments, Personal Injury Protection or third party liability insurance payments. A copy of this document shall be as binding as the document bearing original signatures.

**SECTION 8.** In the event that any Section or provision of this Agreement is determined to be legally void, invalid, or unenforceable, all other Sections and provisions of this Agreement shall remain in full force and effect. Patient may not revoke the assignments and agreements contained in this document without the express written consent of Provider.

IN WITNESS WHEREOF, this agreement has been entered into the day and year set forth below.

_____

**Printed Name of Health Care Recipient "Patient"**

| | |
|---|---|
| _____ | _____ |
| Date | **Patient Signature** |
| _____ | _____ |
| Date | **Parent Signature if Patient is a Minor** |
| _____ | _____ |
| Date | **Witness** |