MOTOR VEHICLE COLLISION HISTORY

Harmony Chiropractic Center, Inc.
5800 Monroe St. A11; Sylvania, OH 43560
419-517-5055

Name: _____ Date: _____

Insurance Company: _____ Policy Number: _____

Address: _____ Name of Agent: _____

(Circle all that apply)

Have you retained an attorney? **No** **Yes** Name of Attorney: _____

COLLISION HISTORY:

Date of Collision: _____ Time of Collision: _____ A.M. P.M.

Number of Vehicles Involved: _____ Did you take pictures? **No** **Yes**

What type of vehicle were you in? Make/Model: _____Year: _____

Were you driving? **No** **Yes** Was it your car? **No** **Yes** If not, whose? _____

If you were a Passenger, where were you? **Front** **Back** **Right Side** **Left Side** Other: _____

What type of vehicle collided with the vehicle you were in? Make/Model:_____

Car **SUV** **Pick-up Truck** **Tractor Trailer** Other: _____

State how the accident happened in your own words: _____

_____

_____

_____

Seat belts on? **No** **Yes** Shoulder harness on? **No** **Yes** Did airbag deploy? **No** **Yes** Broken Seat? **No** **Yes**

Did your head hit the headrest? **No** **Yes** Position of headrest: **Low** **Mid** **High** **Absent**

Where were you looking on impact? **Forward** **Left** **Right** **Down** **Rear-View Mirror** **Over Shoulder**

Were you aware of the impending impact? **No** **Yes** Did you brace for impact? **No** **Yes**

Estimated Speed of Your Vehicle: _____ Estimated Speed of Their Vehicle: _____

What was the posted speed limit? _____ mph Type of road: **2 Lane** **4 Lane** **Gravel** **Tar**

Your vehicle's movement prior to the collision: **Stopped** **Forward** **Backward** **Left Turn** **Right Turn**

Where is the damage on your vehicle? **Driver's Side** **Passenger Side** **Roof**

Front Left **Front Center** **Front Right** **Back Left** **Back Center** **Back Right**

Extent of Visible Damage: **Totaled** **Heavy** **Moderate** **Slight** **No Visible Damage**

Where is the damage on the other person's vehicle? **Driver's Side** **Passenger Side** **Roof**

Front Left **Front Center** **Front Right** **Back Left** **Back Center** **Back Right**

Extent of Visible Damage: **Totaled** **Heavy** **Moderate** **Slight** **No Visible Damage** **Unknown**

Other vehicle's movement prior to the accident: Stopped Forward Backward Left Turn Right Turn

Did any vehicle need to be towed from the scene? **No** **Yes** **If yes,** which vehicle?_____

Harmony Chiropractic Center, Inc.
5800 Monroe St. A11; Sylvania, OH 43560 | 419-517-5055

Name: _____

Did police arrive on the scene? **No Yes** What City, Township or Locality?_____

Was accident report made? **No Yes** Who was ticketed? _____ For?_____

_____

Was it? **Daylight Night Dark Dawn** What were the weather conditions? _____

How long had you been in the car? _____ What were the traffic conditions? _____

Did it happen at a/an: **Stop Sign Traffic Light Intersection Highway Other**

Did your vehicle strike anything after the initial impact? **No Yes** If yes: **Another Car Sign Tree**

Off the Road Other: _____ **Size and Type**: _____

GENERAL SYMPTOMS/INJURIES:

Did your body hit anything inside the vehicle? **No Yes** What part of your body hit what in the vehicle?_____

_____

Did you receive an injury to the head, like a concussion or cut? **No Yes** Describe:_____

Were you completely conscious after the impact? **No Yes Not Sure** Do you remember the impact? **No Yes**

Did EMS/ambulance arrive on scene? **No Yes** Was anyone from scene transported to the hospital? **No Yes**

Did you go to hospital, home, work or other? How?_____

Were you hospitalized? **No Yes** If yes, where and for how long? _____

Did you seek medical care after the collision? **No Yes** Describe: _____

_____

Where did you feel symptoms after the collision?_____

Any other symptoms after the collision? _____

How have symptoms changed after the collision? _____

Have you had any time loss from work? **No Yes** If yes, from _____ to _____

Have you ever had to have any outside help? **No Yes** What type? _____

Were other people in the car with you? **No Yes** Names and Addresses: _____

_____

Were they injured? **No Yes** If yes, please explain: _____

_____

The above information is accurate and has been completed to the best of my knowledge:

Patient Signature: _____ Date: _____

ASSIGNMENT

I was involved in an accident on or around _____(date) in which I was injured for which I have or may have a claim against another person(s) for causing my injuries (referenced as "My Claim"). In consideration of the agreement of **Harmony Chiropractic Center, Inc.** (HCC) to delay billing me personally for medical treatment rendered until resolution of My Claim:

Patient Initials

____ 1. I now assign, without any right to later revoke, a part of any proceeds from My Claim equal to the fees incurred by me to this Clinic for all treatment and other services rendered by this Clinic. I am **NOT** assigning any legal cause of action in My Claim above, but only prospective proceeds. I also assign to the settlement agreement made by or for me in exchange for my signing such insurance company's release of claim. Prior to settlement or other disposition of My Claim, I understand and permit HCC to pursue payment from any other source but me personally, including medical payments coverage in an automobile liability policy.

____ 2. This Assignment, and related documents which I have signed in connection with it, states the entire agreement and my complete understanding regarding HCC's fees. I have not relied on any statements by HCC or the Doctor or other information before making this Assignment. I understand that I remain responsible for any HCC fees not paid out of My Claim.

____ 3. I understand that it is my responsibility during treatment to remain aware of my cumulative account balance for services rendered.

____ 4. I understand that this is an express contract to pay for the services rendered by HCC. I agree to pay my account balance in full and/or direct its payment from My Claim proceeds regardless of whether any other person or entity attempts to or fails to fully reimburse me for it. If I dispute my account balance or treatment rendered, I agree that my remedy will be to resolve it with a separate action from My Claim.

____ 5. I understand that HCC is not obligated to bill my health insurance company for treatment related to My Claim and that my health insurance company will deny care for My Claim when another party, or their insurance, is responsible.

____ 6. NOTICE: I DIRECT ANY INSURANCE COMPANY, ATTORNEY, OR OTHER PERSON WHO HOLDS OR LATER HOLDS ANY PROCEEDS FROM MY CLAIM TO APPLY ANY PROCEEDS FROM MY CLAIM TO MY TOTAL ACCOUNT BALANCE OUT OF THE TOTAL PROCEEDS HELD IN MY BEHALF, UNLESS THE CLINIC CONFIRMS PRIOR PAYMENT OF IT IN WRITING. "TOTAL PROCEEDS" HELD BY AN ATTORNEY FOR MY CLAIM SHALL MEAN PROCEEDS AFTER DEDUCTION OF ATTORNEY FEES.

____ 7. I understand this agreement authorizes representatives of HCC to contact and discuss my case with any interested parties involved in My Claim.

____ 8. I understand that HCC will delay billing me personally for My Claim, but HCC has the discretion to call my medical bills due (especially regarding lack of communication or cooperation by me and/or my attorney). Billing may be made to my health insurance company or to me personally. If the filing limit has passed for my health insurance company, I acknowledge that I am responsible for my medical bills in full.

____ 9. Ohio law governs this Assignment. Jurisdiction shall be in Ohio, and venue shall lie in Lucas County, in which HCC is located, unless required by applicable law to lie in a different county in which I reside. If any portion of this agreement is found to be invalid, the remainder of the agreement remains in effect.

____ 10. I REALIZE THAT I HAVE NOW GIVEN AWAY A PART OF ANY PROCEEDS FROM MY CLAIM. IF I RECEIVE ANY PROCEEDS FROM MY CLAIM, I AGREE TO IMMEDIATELY DETERMINE IF THIS CLINIC HAS BEEN SEPARATELY PAID IN FULL. UNLESS THE CLINIC CONFIRMS FULL PAYMENT IN WRITING, I REALIZE THAT ANY USE BY ME OF THESE PROCEEDS IS TAKING OR CONVERTING MONEY THAT IS THE PROPERTY OF THIS CLINIC.

____ 11. I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND IT.

_____ _____

Patient Signature Patient's Name

_____ _____ _____

Date Signature of Parent or Legal Guardian Staff Witness

Harmony Chiropractic Center, Inc.
5800 Monroe St. A11 ● Sylvania, OH 43560 ● 419-517-5055