Olivieri Chiropractic Inc.

AUTO ACCIDENT INFORMATION FORM

IF YOU NEED MORE SPACE, WRITE ON THE BACK OF THIS PAGE

NAME: _____ AGE: _____ DATE OF BIRTH: _____ SEX: M __ F __
MARITAL STATUS_____ HOME PHONE _____ WORK PHONE _____
ADDRESS _____
E-MAIL ADDRESS _____
ACCIDENT DATE_____ TIME_____ WHERE DID IT HAPPEN? _____
GIVE A DETAILED DESCRIPTION OF HOW THIS ACCIDENT/INJURY HAPPENED. _____
_____
WHAT PARTS OF YOUR BODY WERE HURT? _____
HAVE YOU EVER HURT THESE PARTS OF YOUR BODY BEFORE? _____ IF YES, HOW AND WHEN _____
_____
WHERE DO YOU NOW FEEL PAIN? _____
WHAT SYMPTOMS/PROBLEMS BEGAN FROM THE ACCIDENT? _____
WHAT SYMPTOMS/PROBLEMS DO YOU FEEL RIGHT NOW? _____
HAVE YOU EVER HAD THESE SYMPTOMS/PROBLEMS BEFORE THE ACCIDENT? _____
IF YES, WHEN AND FROM WHAT? _____
WHERE WERE YOU IN THE VEHICLE? _____ WHAT TYPE OF VEHICLE? _____
WHAT WAS THE SPEED OF YOUR CAR AT IMPACT? _____ WERE YOU ACCELERATING AT IMPACT? _____
WHAT WAS YOUR VEHICLE DOING JUST BEFORE IMPACT? _____
WHAT WAS THE POINT OF IMPACT ON YOUR CAR? _____
HOW MUCH DAMAGE WAS DONE TO YOUR CAR? [ ] UNKNOWN [ ] APPROXIMATELY $_____
DESCRIBE THE ROAD CONDITIONS AND VISIBILITY _____
WERE OTHER VEHICLES INVOLVED? HOW MANY? _____WAS POLICE REPORT FILED? _____
WHICH VEHICLE HIT THE OTHER? _____
AIRBAGS DEPLOY?_____ LOSE CONSCIOUSNESS?_____ EMERGENCY CARE AT SCENE? _____
WHAT WAS THE POSITION OF YOUR HEADREST? _____
WERE YOU WEARING A SEAT BELT? _____ WHAT TYPE _____
IMMEDIATELY AFTER THE ACCIDENT WHERE DID YOU GO OR WHERE WERE YOU TAKEN? _____
_____
WERE YOU PREPARED FOR IMPACT? _____ WAS YOUR FOOT ON THE BRAKE AT IMPACT?_____
DID THE IMPACT KNOCK YOUR FOOT OFF THE BRAKE? _____ WHAT WAS THE POSITION OF YOUR HEAD AND NECK AT IMPACT? _____
WHAT WAS THE OTHER VEHICLE TYPE? _____SPEED OF OTHER VEHICLE AT IMPACT _____
WHAT WAS THE OTHER VEHICLE'S POINT OF IMPACT? _____
WAS THE OTHER VEHICLE ACCELERATING AT IMPACT? _____ WHAT WAS THE OTHER VEHICLE DOING JUST BEFORE IMPACT? _____
LIST ALL DOCTORS THAT YOU HAVE BEEN EXAMINED OR TREATED BY SINCE THIS ACCIDENT. (INCLUDE DOCTOR'S NAME, ADDRESS, TREATMENT YOU WERE GIVEN, REASON FOR TREATMENT, AND WHAT EFFECT THE TREATMENT HAD ON YOU)

_____
_____
_____

DID YOU MISS WORK DUE TO THIS ACCIDENT? _____WHAT IS THE FIRST DATE YOU MISSED _____
HAVE YOU RETURNED TO WORK _____WHEN? _____BETWEEN THESE DATES DID YOU DO ANY WORK? _____ IF YES, ON WHAT DATES _____ WAS ANYONE ELSE IN THE CAR WITH YOU? _____ WHO & WHAT RELATIONSHIP DOES THAT PERSON(S) HAVE TO YOU? _____
HAS THAT PERSON(S) BEEN TREATED DUE TO THIS ACCIDENT? _____ DID YOU REPORT THIS TO YOUR AUTO INSURANCE? _____ IS THERE ANYTHING YOU CANNOT DO AS A RESULT OF THIS ACCIDENT?
PLEASE BE SPECIFIC ABOUT WHAT YOU CANNOT DO: _____
_____
_____

AUTO INSURANCE INFORMATION:

Insurance Company:_____ Phone Number:_____

Policy Number:_____ Effective Date:_____

Accident Claim Number:_____ Adjuster's Name:_____

Adjuster's Phone Number:_____ Adjuster's Fax Number:_____

Claim Billing Address:_____

ATTORNEY INFORMATION

Name: _____

Address:_____

Phone Number:_____

Fax Number: _____

Case Number:_____

To the best of my knowledge, all information above is accurate and true. I authorize my insurance carrier(s), trustees, executors, accountant, custodian & or attorney to make payment directly to Olivieri Chiropractic Inc for services rendered to me/my family. I agree to pay any balance left unpaid. I authorize Olivieri Chiropractic Inc to send bills/claims &/or reports for services rendered directly to my insurance carrier & or attorney and to release to my insurance carrier & or attorney any information needed to process my claim. I acknowledge that I am completely and fully responsible for paying all fees that I or my family incurs with Olivieri Chiropractic Inc. If I have financial difficulties/hardships, I shall pay Olivieri Chiropractic Inc according to the terms of any agreement that I make with Olivieri Chiropractic Inc. This authorization serves as a Doctor's Lien, directing my attorney to withhold from any settlement, judgment, or verdict which may be paid to my attorney or me whatever sum is needed to protect Olivieri Chiropractic Inc, and to pay Olivieri Chiropractic Inc directly from those proceeds. If Olivieri Chiropractic Inc. has to resort to collection proceedings against me, I agree to pay all collection costs including the fees of collection agents, attorneys, and court costs, in addition to paying all fees due Olivieri Chiropractic Inc for services rendered to me or my family. I authorize Olivieri Chiropractic Inc and staff to call me on the telephone to discuss appointments, treatment information, and/or any other details related to me/my family's therapy and treatment. Olivieri Chiropractic Inc. staff may leave messages about appointments on my answering machine. If I am unavailable or incapacitated, I authorize Olivieri Chiropractic Inc and/or staff to discuss my case with my spouse, parents, adult children, and/or other health care providers. Olivieri Chiropractic Inc is authorized to release any and all information requested to any other health care provider involved in my care and treatment.

Today's date:_____ Your signature:_____

Olivieri
Chiropractic inc.

250 Newport Center Dr, Ste 102
Newport Beach, CA 92660
Ph 949.760.5437
Fx 949.760.5467
info@olivieriwellness.com

Notice of Doctor's Lien

Patient's Printed Name: _____

Claim Number: _____

I do hereby authorize Olivieri Chiropractic Inc. to furnish you with a full report of their examination, diagnosis, treatment, prognosis, etc., of myself with regard to the accident which occurred on _____. (Date of accident)

I hereby authorize and direct you to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due this office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor. And I hereby give a Lien on my case to said doctor against any and all proceeds of settlement, judgment, or verdict which may be paid to myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by the insurance carrier. I hereby instruct that in the event an attorney is retained in this matter, the attorney honor this Lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

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

The undersigned does hereby agree to observe 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 said doctor above-named.

_____ _____
Date Patient's Signature

_____ _____ _____
Date Insurance Adjuster's Signature Adjuster's Printed Name

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Notice of Doctor's Lien

Patient's Printed Name: _____ Date of Accident: _____

I do hereby authorize Olivieri Chiropractic Inc. to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc., of myself with regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing for medical service rendered me both by reason of this accident and by reason of any other bills that are due this office 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 give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

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

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter buy signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

_____ _____
Date Patient's Signature

The undersigned being attorney of record for the above patient does hereby agree to observe 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 protect said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

_____ _____ _____
Date Attorney's Signature Attorney's Printed Name