MOTOR VEHICLE ACCIDENT AND/OR WORKER'S COMPENSATION INFORMATION

Motor Vehicle Accident/Personal Injury (if applicable)

>**Date of Accident:** ____/____/_____ **What State did the accident occur in:** _____
>Have you reported the accident to your auto insurance company? ○ **Y** ○ **N**
>If yes when? ____/____/_____ Have you filed a PIP or NO FAULT application with your auto insurance carrier? ○ **Y** ○ **N**
>Do you have an open or pending case with them? ○ **Y** ○ **N**
>Were you the driver of the vehicle you were in? ○ **Y** ○ **N**
>Was the vehicle you were in at fault? ○ **Y** ○ **N**
>Have you received any other medical treatment for injuries related to this accident? ○ **Y** ○ **N**

Your Auto Insurance Carrier's Name: _____ Policy #_____

Claim Number# _____

Adjuster's Name: _____ Phone # _____

3rd Party Auto Insurance Carrier's Name: _____ Policy #_____

Claim Number# _____

Adjuster's Name: _____ Phone #_____

Do you have an attorney? ○ **Y** ○ **N** If yes, Name and phone # _____

If no, would you like for us to recommend one? ○ **Y** ○ **N**

Worker's Compensation (if applicable)

Date of Injury: ____/____/_____ **State the accident occurred in:** _____

Have you or your employer filed a claim? ○ **Y** ○ **N** If yes, When? ____/_____/_____

Is your case open/pending? ○ **Y** ○ **N** Name of Physician who Referred you for Chiro/PT : _____

Worker's Comp Insurance Carrier Name _____ Phone # _____

Claim #: _____ Adjuster's Name _____Phone #_____

Do you have an attorney? ○ **Y** ○ **N** If yes, name and phone # _____
If no, would you like for us to recommend one? ○ **Y** ○ **N**

By signing below I confirm that the information provided above is true to the best of my knowledge. I understand that I may be billed administrative and filling fees for withholding information as it relates to my medical history or insurance coverage.

I understand that Sport and Spine Rehab / Kaizo Health will submit claims on my behalf to the appropriate insurance carriers using the information I have given them. I am aware that it if my treatment is related to an auto accident or work comp injury it is my responsibility to also adhere to the guidelines of my Major Medical insurance so that in the event my personal injury case closes, my health insurance will be billed and I will be responsible for any co- payments, deductibles or non-covered services.

Print Name_____ **Signature**_____ **Date** _____
(Parent/Guardian if patient is a minor)

Witness Signature _____ **Date**_____

WAIVER FOR WORKER'S COMPENSATION

I, _____ am fully aware that my worker's compensation insurance will be billed for all medical services provided by Sport and Spine Rehab/Kaizo Health. I also understand that my private health insurance information is needed on this day as well.

If for any reason worker's compensation is denied I give permission to Sport and Spine Rehab/Kaizo Health to bill my private health insurance. Benefits quoted by my private health insurance company are NOT a guarantee of payment.

Sport and Spine Rehab/ Kaizo Health will make every attempt to receive authorization for treatment from the worker's compensation insurance company. However, if the insurance company does not provide this authorization in a timely manner, Sport and Spine Rehab/Kaizo Health will submit claims as a courtesy and process claims to my private health insurance company. I will be responsible for meeting any deductible and paying any co-pays due at the time of the visit.

If authorization is received by the worker's compensation insurance carrier but they do not authorize additional visits due to an Independent Medical Exam, or as a result of a decision that has been made by the Nurse Case Manager, or by the patient discontinuing treatement with the Doctor's consent, I will also be responsible for any outstanding balances and Sport and Spine Rehab/Kaizo Health will no longer accept assignment. It will be important that I come in for a final visit in order to be discharged from care.

In addition to the above, if I have an Attorney who is representing my worker's compensation case, the following will be done:

- A call will be made to notify the attorney that no further authorization was approved for the given reason. The attorney should provide a hearing date with the courts so that my services may get covered.
- If the attorney has dropped the case and no longer represents me, and worker's compensation has declined payment on my case, Sport and Spine Rehab/Kaizo Health will bill all outstanding services to my private health insurance.
- If no private health insurance information is provided to Sport and Spine Rehab/Kaizo Health, I will be responsible for the full balance on all services.
- If payment arrangements are made but not kept, the account will be turned over to collections and I will be required to pay my full balance, an additional collection fee of up to 25% of my balance, all court costs, and 33% of Sport and Spine Rehab/Kaizo Health's attorney fees.

I have read, or have had read to me, the above information and I understand my rights and responsibilites. I have also had the opportunity to ask questions about this consent. By signing below, I agree to the above conditions. I intent this consent form to cover the entire course of treatment for my present condition and for any future condition I may seek treatment for.

Patient's Printed Name: _____ Accident Date: _____

Patient's Signature: _____ Date: _____

Parent/Guardian Signature for minor: _____

Witness Signature: _____ Date: _____

PIP INFORMATION - Attorney fills out this box

if available please provide PIP info for your client

Car Insurance (PIP) carrier name: _____

Claim # _____

Adjuster's Name:_____ Phone #:_____

AUTHORIZATION AND ASSIGNMENT

Patient (or legal guardian) fills out this section

I, _____ hereby authorize Sport and Spine Rehab/Kaizo Health and any of its affiliate companies to furnish, upon request, to my attorney, _____ whose signature appears below, copies of medical copies of medical reports of examination, diagnoses, treatment, prognosis, etc. pertaining, but not necessarily limited to my condition resulting from injuries sustained on _____. I hereby irrevocably authorize and direct said attorney receiving such medical reports to pay my physician's charge for services rendered by them, or any balance thereof, which shall include their charge for attendance in court, if required as an expert witness whether they testify or not, and for reports made of depositions given in this matter. Unless the Sport and Spine Rehab/Kaizo Health doctor is instructed otherwise, they will assume that a narrative report is expected upon my release from their care. Said payment is to be made from any monies received by said attorney as a result of compromise or by way of collection of a judgment on my claim for injuries sustained on the above date. Payment of this amount as herein directed shall be the same as if paid by me. This authorization to pay my physician shall constitute and be deemed as assignment of so much of recovery as shall cover the aforesaid bill. I am also authorizing my PIP to be mailed and paid directly to my physician Sport and Spine Rehab/Kaizo Health. I also authorize Sport and Spine Rehab/Kaizo Health to file for and collect their fees through either my health insurance and/or Personal Injury Protection Insurance if and when available. In the event my Personal Injury Protection coverage is paid directly to me, I agree to pay Sport and Spine Rehab/Kaizo Health immediately from these proceeds, with this bill taking precedence over any other financial demands which may have arisen as a result of this accident. I understand that payment to my physician for professional services is not to be delayed during the pendency of my claim. In the event of any dispute as to the charge for services rendered, I hereby authorize and direct my attorney to withhold the full sum claimed by my physician until such time as the matter is settled by compromise or judgment. It is agreed that nothing herein relieves me of the primary responsibility and obligation of paying my physician for the services rendered, and that payment by me for said medical services is not contingent upon any settlement, judgment, or verdict by which I may eventually recover said fee. In the event that my claim has not been settled within 180 days of my release from Sport and Spine Rehab/Kaizo Health, I agree to pay any remaining balance due on my account in full at that time.

PLEASE PRINT NAME CLEARLY

PLEASE PRINT ATTORNEY'S NAME

DATE OF ACCIDENT

_____ _____

Signature Date

_____ _____

Witness Date

ATTORNEY FILLS OUT THIS SECTION

I, _____, accept the above assignment and agree to observe the terms set forth, and to withhold such sums from my settlement, judgment, or verdict as may be necessary to adequately protect Sport and Spine Rehab/Kaizo Health interest.

_____ _____

Attorney's Signature Date

Sport and Spine Rehab
Wintergreen Plaza
827 E Rockville Pike
Rockville, MD 20852
303.251.2777

Sport and Spine Rehab of McLean
6845 Elm Street, Ste 425
McLean, VA 22101
703.448.5799

Metro Sport and Spine Rehab
Metro 400 Building
4301 Garden City Drive, Ste 104
Landover, MD 20785
301.577.1115

Sport and Spine Rehab of Fairfax
3925 Chain Bridge Road, Suite 101
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703-890-2222

Sport and Spine Rehab of Fort Washington
9300 Livingston Road
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301.203.6734