Parliament Chiropractic, LLC
Automobile Collision Personal Injury Form

If the injury you are seeking treatment for did not result from an automobile collision, please alert the receptionist.

General Information:

Patient's Name:________________________ Today's Date:___________________ Date of Injury:__________________________

Did your injuries occur in the course of employment/on the job? Yes ☐No ☐(If Yes, please alert receptionist)

Please explain how the accident occurred: ____

____

Where are you hurting as a result of the accident? ____

____

Have you ever had an injury to the same area where you are hurting now?☐Yes ☐No

If "Yes" state when and how you were injured:____

____

Have you lost any days of work? ☐ Yes ☐ No Dates:___________________ Date last worked:_____________________

Was a police report filled out? ☐Yes ☐ No If so, in what city was it filed? ______________________________________

Did you require post-accident hospitalization (Emergency Room)? ☐Yes ☐ No

If "Yes", hospital name:__________________________ Treatments done (including Ambulance, X-rays, etc):__________________

Billing Information:

<u>If you do not provide correct and complete information, you will be personally billed for your treatment. Billing the auto insurance company is a courtesy and if the information is not correct we will send the bills to you. Please call your adjustor BEFORE filling this form out to confirm your claim number, their contact information, and their fax number.</u>

Name of insurance company or entity being billed for your treatment: ____

Have you filed a claim with the insurance company you intend to bill for treatment? ☐Yes ☐ No

Name of adjustor: _______________________________________ Claim Number:____

Adjustor phone number: __________________________________ Fax Number: ____________________________________

Have you retained an attorney to represent you? ☐ Yes ☐ No

Attorney's Name: __________________________________ Company Name: ____

Phone: ____________________________________ Fax: ____

Details for Auto Collision:

Location of the accident: ____

You were: ☐ Driver ☐Front-seat passenger ☐Rear seat passenger ☐Motorcycle rider ☐Motorcycle passenger ☐Other

Vehicle Driven By (If you were not the driver): _____________________________________

Your vehicle (year, make, model):____

Your estimated speed at the moment of crash:__________ ☐Stopped ☐ Slowing ☐ Accelerating

Other vehicle (year, make, model):____

Other vehicle estimated speed at the moment of crash:__________ ☐Stopped ☐ Slowing ☐ Accelerating

Did your car strike other(s) involved? ☐Yes ☐No Or did the other car strike yours? ☐Yes ☐ No

Which party was at fault? ____.

Time of Accident:___________ ☐AM☐PM Road conditions: ☐Dry ☐Damp ☐Wet ☐Snow ☐Ice ☐Other:_________________

Were you seat-belted upon impact? ☐ Yes ☐No Were any airbags deployed? ☐Yes ☐No

At the time of impact, was your head: ☐Facing forward ☐To the left ☐To the right

Did anything out of the ordinary happen (ex: glasses jerked off face, hat jerked off head, etc.)?

____

Name of the insurance company covering the vehicle that you were driver/passenger in: ___________________________

Name of the insurance company covering the other vehicle: ____

PATIENT'S SIGNATURE: ____ **DATE:**___________________________

Return to:
Parliament Chiropractic, LLC
2665 E. Tudor Rd, Suite 201
Anchorage, AK 99507
Phone: (907)222-5100 Fax: (907) 222-5412
www.ParliamentChiropractic.com

Third Party Medical Lien and Assignment
Anchorage Recording District

Patient: ____

Claim #: ____

Date of Injury: ____

I do hereby authorize Parliament Chiropractic, LLC to furnish my attorney/insurance carrier with a full report of case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness of this case.

I hereby authorize and direct ____________________________________ Insurance Company and or Attorney to pay Parliament Chiropractic, LLC such sums as may be due and owing for chiropractic services rendered me by reason of the accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate Parliament Chiropractic. And I hereby further request that payments be made directly to said provider which would otherwise be paid to myself, as the result of the treatment charges incurred for injuries in connection with this accident. This is a direct assignment of my rights and benefits.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by Parliament Chiropractic, LLC for services rendered me and this agreement is made solely for Parliament Chiropractic's protection and consideration for payment. And I further understand that such payments are not contingent on any settlement, judgment or verdict which I may eventually recover.

Patient Signature: ______________________________ Date: __________________