Lakeway Spine Center - Auto Accident History

Today's Date: ___/___/_

Patient Name: _____ Date of Accident: ___/___/____

Your Vehicle Type: ❑ Small Car ❑ Mid-Size Car ❑ Full-sized Car ❑ SUV ❑ Pick-up ❑ Other:_____
Other Vehicle Type: ❑ Small Car ❑ Mid-Size Car ❑ Full-sized Car ❑ SUV ❑ Pick-up ❑ Other: _____
I was the: ❑ Driver ❑ Front Passenger ❑ Back Passenger ❑ Pedestrian
Were you wearing a seatbelt? ❑ Yes ❑ No Did the Airbags deploy? ❑ Yes ❑ No

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Description of Accident: (Check all that apply)

- ❑ Side-swiped ❑ "T-Boned" ❑ The other vehicle ran a red light / stop sign.
  Which side? ❑ Broadside (❑ R ❑ L) ❑ Front Panel (❑ R ❑ L) ❑ Back Panel (❑ R ❑ L)
- Rear-ended by another vehicle while I was:
  - ❑ Stopped for traffic ❑ Stopped at red light ❑ Stopped at stop sign
  - ❑ Slowing down for traffic/light ❑ Slowing down to merge into traffic
- ❑ Pushed into the vehicle in front of me ❑ Another vehicle hit me head-on
- ❑ Another vehicle struck the side of my car:
  ❑ Side-swiped ❑ "T-Boned" ❑ The other vehicle ran a red light / stop sign.
  Which side? ❑ Broadside (❑ R ❑ L) ❑ Front Panel (❑ R ❑ L) ❑ Back Panel (❑ R ❑ L)
- ❑ I rear-ended another vehicle
- ❑ I hit another vehicle head-on
- ❑ I hit the side of another vehicle
  ❑ Side-swiped ❑ "T-Boned" ❑ I ran a red light / stop sign.
  Which side? ❑ Broadside (❑ R ❑ L) ❑ Front Panel (❑ R ❑ L) ❑ Back Panel (❑ R ❑ L)
- ❑ Other: Please describe:

_____

Were you aware of the impending impact? ❑ Yes ❑ No Were you braced? ❑ Yes ❑ No
Head Position: ❑ Facing forward ❑ Looking up ❑ Turned right ❑ Turned left
Body Position: ❑ Facing forward ❑ Looking up ❑ Turned right ❑ Turned left

Did you strike anything in your vehicle? ❑ Steering Column ❑ Back of seat / headrest ❑ Dash
❑ Windshield ❑ Door frame ❑ Side window ❑ Other: _____

Indicate any symptoms you experienced immediately after the impact?

- ❑ Felt no immediate pain. ❑ Pain began later. When? _____
- ❑ Headache ❑ Dizziness ❑ Neck pain (❑ R ❑ L) ❑ Mid-back Pain (❑ R ❑ L)
- ❑ Low back pain (❑ R ❑ L) ❑ Upper extremity pain (❑ R ❑ L) ❑ Lower extremity pain (❑ R ❑ L)
- ❑ Other: _____

What did you do after the accident? ❑ Went home and rested. ❑ Went about normal business
❑ Went with EMS to Hospital. Which one? _____ ❑ Doctored myself

Have you sought other treatment for this accident? ❑ No ❑ My PCP Who:_____
❑ Other Doctor Who?_____ Specialty _____

What procedures have been performed? ❑ None ❑ X-rays ❑ MRI / CT Scan
❑ Examination ❑ Manipulation / Physical Therapy ❑ Massage Therapy

Auto Accident Insurance Form

Patient Name: _____ Today's Date: _____

Date of MVA: _____ Insurance Company: _____

Mailing Address: _____

Phone #: _____ Fax #: _____

Adjuster Name: _____ Adj Phone: _____

Adj Fax #: _____ Adj E-mail: _____

Policy #: _____ Claim #: _____

Policy Holder Name: _____

Where to Send Claims:

- ❑ Address Above
- ❑ Fax Above Attn:_____
- ❑ Other: _____

When to Send Claims:

- ❑ After Each Visit
- ❑ At End of Treatment
- ❑ Other: _____

Date Contractual Lien Was Signed: _____

Date Spoke to Adjuster: _____

CONTRACTUAL LIEN

I hereby authorize and direct you, the insurance company, and/or my attorney, to pay directly to Lakeway Spine Center, Inc. such sums as may be due and owing this office for services rendered to me, both by reason of accident, of illness and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, liability benefits, health and accident benefits, workmen's compensation benefits, or any other insurance benefits obligated reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office.

I hereby further give a lien to said office against any and all insurance named herein, and any and all proceeds of any settlement, judgment or verdict that may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided. I understand that I remain personally responsible for the total amounts due the office for their services. I further understand and agree that this assignment, lien and authorization does not contribute any consideration for the office to await payments and they may demand payment from me upon rendering services at their option. I authorize this office to release any information pertinent to my case to any insurance company or attorney to facilitate collection under this assignment, lien and authorization.

I agree that the above mentioned office be given power of attorney to endorse my name on any and all checks for payment of my doctor bill. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this office for all costs of such collection efforts including, but not limited to all court costs and all attorney fees.

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, but will require me to make payments on my current balance.
By signing below, I acknowledge I have read, understand and agree to the above provisions.

Patient Name: _____ Today's Date: _____

Signature: _____ Date of Injury: _____

Name of Parent / Guardian: _____ Name from Lakeway Spine: _____

Signature of Parent / Guardian: _____ Signature from Lakeway Spine: _____

Assignment of Benefits

According to Texas Insurance Code-Section 1204.054

I, the assignor hereby convey the assignment of benefits to the assignee, LAKEWAY SPINE CENTER, INC. I further grant financial consideration to LAKEWAY SPINE CENTER, INC. I direct and authorize my insurance company to pay directly LAKEWAY SPINE CENTER, INC., any and all sums due and owing for services rendered to me both by reasons of accident, illness and by reason of any other bills that are due to LAKEWAY SPINE CENTER, INC.

Lakeway Spine Center
1213 RR 620 South,Suite 203
Austin, TX 78734

Tax ID: 061772496

Name (Printed): _____ DOB: _____

Name (Signature): _____ SS#: _____

Date: _____