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By Appointment only

MEDICAL REPORTS AND DOCTOR'S LIENS

I do hereby authorize this doctor's office to furnish to you, my attorney, a full report of the examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved.

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

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

Please acknowledge this letter by 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 but will require me to pay on my account and keep it on a current basis.

Dated_____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. Judgement or verdict as may be necessary to adequately protect said doctor avoce named.

Dated_____Attorney's signature_____

Please date, sign, and return one copy to doctor's office.

Keep a copy for records.

A photocopy of this form shall be considered as valid as the original.

IF YOU HAVE BEEN IN AN ACCIDENT, PLEASE COMPLETE THE FOLLOWING QUESTION:

Date of Accident_____ Hour_____ AM/PM

Location_____

Were you the: ☐ Driver ☐ Passenger (R/L Front/Back/Middle) ☐Pedestrian ☐Other _____

Were you wearing a seatbelt? ☐ Yes ☐ No

Did it include a shoulder harness? ☐ Yes ☐ No

Was your car equipped with headrests? ☐ Yes ☐ No

Were they fully raised? ☐ Yes ☐ No

Describe the vehicle you were in:

☐ Late Model ☐ Compact Car ☐ Mini-Van ☐ Light Pickup ☐ Station wagon ☐Older Model ☐ Midsize Car
☐ Large Van ☐ Half-Ton Pickup ☐SUV ☐ Larger Car ☐ Other: _____

Describe the other vehicle:

☐ Late Model ☐ Compact Car ☐ Mini-Van ☐ Light Pickup ☐ Station wagon ☐Older Model ☐ Midsize Car
☐ Large Van ☐ Half-Ton Pickup ☐SUV ☐ Larger Car ☐ Other: _____

Was your car fully stopped at the time of the impact? ☐Yes ☐ No

Estimate the speed of the vehicle you were in: _____ MPH

The other vehicle: _____ MPH

Were you pushed into the vehicle in front? ☐Yes ☐ No

Were you aware of the impending collision or did the impact catch you by surprise?_____

_____

Describe in detail how the accident happened:

_____

_____

_____

Describe what happened to your body on impact, for instance “Thrown Forward” or “Hit head against the window”

_____

_____

_____

ACCIDENT QUESTIONNAIRE- PAGE 2

Did you lose consciousness? ☐ Yes ☐ No If 'Yes,' for how long? _____

What bruises or bleeding cuts did you receive:_____

Did you feel pain immediately? ☐ Yes ☐ No If 'Yes,' where_____

_____

If not immediately, when did you begin to feel pain and where _____

_____

Did paramedics come? ☐ Yes ☐ No

Were you taken to the hospital after the accident? ☐ Yes ☐ No If 'Yes,' were you:

☐ Taken by paramedics ☐ Driven by someone else ☐ Drove yourself

When: ☐ Immediately afterwards ☐ Later (How much later?) _____

Which Hospital? _____

What parts of your body were x-rayed _____

Any other tests such as MRI or CT Scans? _____

How long were you in the hospital? _____

What Medications or other treatments were you given at the hospital_____

_____

Did you see any other doctors/chiropractors/physical therapists/etc. ☐ Yes ☐ No

If 'Yes,' Please List:

Name _____ Date (approximate is OK)_____

Treatments/Medications/Tests _____

Name _____ Date (approximate is OK)_____

Treatments/Medications/Tests _____

Name _____ Date (approximate is OK)_____

Treatments/Medications/Tests _____

Comment on the effectiveness of past treatments_____

Have you been using any home remedies ☐ Yes ☐ No If so, what, and were they effective? _____

_____

ACCIDENT QUESTIONNAIRE- PAGE 3

LIST THE EXTENT OF YOUR INJURIES AS YOU KNOW THEM:

_____

_____

_____

Since the injury, are your symptoms ☐ Improving ☐ Getting Worse ☐ Staying the same?

List the dates of any previous auto or other accidents, injuries received and any treatment received:

_____

_____

_____

_____

INSURANCE INFORMATION

(Note: The following information should be filled out completely. Many people are legally entitled to multiple or overlapping benefits under multiple policies. All relevant policies should therefore be investigated.)

- My Auto Ins. Company_____Policy #_____Claim_____

-Driver of Other Vehicle (Name) _____

Ins.Company_____Policy#_____Claim#_____

-Driver of Vehicle in which you were Injured (Name)_____

Ins.Company_____Policy#_____Claim#_____

-My Group Health Ins. Co. (Major Medical)_____

My Spouses Group Health Ins. Co_____

_____

Have You Retained an Attorney ☐ Yes ☐ No. If 'Yes,' Who?_____

_____

ACCIDENT QUESTIONNAIRE - PAGE 4

You may illustrate your accident here: