Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Cell Phone: _____

Date of Accident: _____

Attorney: _____ Phone: _____

Add.: _____ Contact: _____

Add.: _____ Fax: _____

At Fault Insurance Info

Claim Number: _____

Ins. Co.: _____

Address: _____

Add.: _____

Adjustor: _____

Adjustor Phone: _____

Med Pay (Your Auto Insurance)

CL No.: _____

Ins. Co.: _____

Add.: _____

Add.: _____

Adj: _____

Adj Phone: _____

Second At Fault Insurance Info

Claim Number: _____

Ins. Co.: _____

Address: _____

Add.: _____

Adjustor: _____

Adjustor Phone: _____

Dear Patient,

Please fill out the top portion of this page completely. Please let us know if you are unable to provide any of the above information. This information helps us to ensure the At Fault Party and their insurance company get all the information needed to resolve your claim with minimal delay. This form is not a release of your responsibility of payment for the services you receive during the course of treatment with our office.

County liens are filed on all accidents per our office policy. If you have any questions or concerns about the lien, please feel free to ask.

Insurance companies will send you a Consent to Release Information form that, UNLESS you have retained an attorney, needs to be filled out and sent back to the insurance company.

If you have retained an attorney, please inform us immediately. Contact your attorney regarding any paperwork you receive from the insurance company for guidance on how to proceed.

Thank you,

Lifecare Chiropractic

_____ _____

Patient Name Date

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

Patient Name:

Date of Birth:

Date of Injury:

Social Security Number:

I authorize any physician, dentist., chiropractor, hospital, pharmacist, medical professional, health care provider, insurance company, worker compensation provider or employer to disclose all information about past and present medical care, history, physical condition, and injuries including itemized statements to Complete Injury Management for the purpose of review and evaluation in connection with a legal claim.

I agree this authorization will remain valid until the conclusion of my claim. I understand I have the right to revoke this authorization at any time and must do so in writing.

I understand I am entitled to a copy of this authorization. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand signing this authorization may not condition treatment, payment, enrollment or eligibility for benefits.

TO _____ _____

Name of ealthcare Provider/Physician/Facility **Phone**

Please send records to:

Complete Injury Management
7380 West Sahara Avenue, Suite 110
Las Vegas, NV 89117
Phone: 602.497.4976
Fax: 602.795.3331

_____ _____ _____

Signature of Patient or Legal Representative **Relationship to Patient** **Date**

Lifecare Chiropractic
1830 S. Alma School Rd., #135
Mesa, AZ 85210
Ph: 480-839-2273
Fax: 480-907-3061

WAIVER OF HEALTH INSURANCE BENEFITS

1, _____ , do hereby acknowledge that I have health insurance and that I have certain rights and protections granted to me pursuant to ARS 33-931 relating to liens. Due to my provider agreeing to await payment for services rendered, resulting from my accident of _____ , I elect to not use any of my health insurance benefits that may be available to me, This waiver of benefits applies only to the aforementioned accident and not any other services that may be provided once my case has resolved. I acknowledge I am personally responsible for all services and amounts payable to Dr. Bogash and/or Dr. Everts, should the doctor not be reimbursed through my settlement proceeds, award or other payments received by me for my accident. I specifically give permission to Dr. Bogash and/or Dr. Everts to file a lien, pursuant to ARS 33-931, to protect his right to be paid for services rendered.

Dated: _____ Patient Signature: _____

Lifecare Chiropractic
1830 S. Alma School Rd., #135
Mesa, AZ 85210
Ph: 480-839-2273
Fax: 480-907-3061

HEALTH CARE PROVIDER LIEN

Patient: _____

Attorney: _____

_____

_____

Date of Injury: _____

I authorize LIFECARE CHIROPRACTIC to furnish my attorney, including any successor legal counsel, with a complete report of my case history, examination findings, diagnosis, relevant treatment information, and the prognosis of my condition, along with the bill for services rendered concerning my injury sustained on the above date.

I hereby give an irrevocable lien to LIFECARE CHIROPRACTIC against any and all proceeds, which I may become entitled and pain in connection with the settlement of claims or litigation arising out of the injuries for which I have been treated in connection herein. I further authorize and direct any and all legal representatives to pay directly to LIFECARE CHIROPRACTIC such sums as may then be due and owning to LIFECARE CHIROPRACTIC for services provided to me and to withhold such sums from settlement claim, judgment, or verdict as necessary to properly protect LIFECARE CHIROPRACTIC.

I understand I am fully responsible to LIFECARE CHIROPRACTIC for all bills submitted by them for services provided to me. I further understand I am making this contractual covenant solely for LIFECARE CHIROPRACTIC additional protection and in consideration for their agreeing to wait for payment and for their relying on prompt payment when my claim is resolved. I also recognize such payment is not dependent on any settlement, claim, judgment, or verdict by which I may eventually recover said fees.

Dated: _____ Patient Signature: _____

Notice via a duly executed copy of this Health Care Provider Lien addressed to the above-named attorney or patient-designated successor legal counsel shall be deemed effective upon receipt when (1) personally delivered or (ii) sent by facsimile or email transmission during business hours or (iii) by certified U.S. mail, postage prepaid return receipt requested.