PERSONAL INJURY/AUTOMOBILE ACCIDENT FINANCIAL POLICY

Our Personal Injury/Automobile Insurance Assignment Program is designed to render you immediate care and keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your insurance carrier on your behalf and wait up to six months for payment. Please remember, however, that you are ultimately responsible for payment of all services rendered to you regardless of insurance coverage or settlement status. Termination of care prior to your doctor's release will result in all balances being due immediately. Please notify us if you are using an attorney. Listed below are payment options for your personal injury claim.

MEDICAL PAYMENTS

"Medical Payments" or "Med-Pay" is part of your own auto insurance policy which will immediately cover the costs of your medical expenses given by a licensed health care provider and those of any passengers in your car, up to a certain limit, regardless of fault. Senate Bill 08-011, effective January 01, 2009, made Med-Pay benefits mandatory on all auto insurance policies unless specifically rejected in writing or declined during the application process. If payment is made by this method, and you are not at fault, your insurance premiums will not be increased, and you will not have to repay any benefits. This will allow you to get the treatment you need for your injuries without the hassle of dealing with the other party's insurance company. Med-Pay is primary for services rendered to personal injury patients when available.

HEALTH INSURANCE

Your Group or Individual Health Insurance may cover your medical expenses resulting from injuries sustained in an automobile accident. If coverage is available, your health insurance company may seek reimbursement for payments made from the third party. We will assist you in verifying your coverage. You will be responsible for any co-payments or deductibles that your policy requires. In certain instances, we may be able to wait for payment for copays and deductibles until a settlement is reached with the third party.

THIRD PARTY

Colorado is currently an "at-fault" state regarding payment of claims resulting from an automobile accident or personal injury. This means the responsible party, or his or her insurance, should cover the cost of medically necessary treatment given by a licensed health care provider. Such claims are considered for payment when all treatment is complete and a settlement is reached with the third party. If available, Med-Pay and your personal health insurance will be billed before attempting collection from the at-fault party. We will accept a medical provider's lien and a credit card guarantee from you and wait up to six months after the conclusion of your care for payment if no other payment options exist.

SELF PAY

You also have the option of paying at the time of service for your care and seeking reimbursement from the responsible party/insurance carrier yourself. If you prefer to do this, we will provide itemized statements along with detailed records and reports upon request.

All financial and claims documents must be completed prior to the second visit or no treatment can be given.

I have read and understand the personal injury/automobile accident financial policy of Complete Chiropractic, P.C. I understand that I am ultimately responsible for any services rendered to me by Complete Chiropractic, P.C. Payment for services is not contingent upon my insurance coverage or settlement with a third party. I understand that if I terminate care outside my doctor's recommendations, any balances will be due immediately.

_____ _____ /_____ /_____ **Patient /**

Guardian Signature **Date**

PERSONAL INJURY / AUTOMOBILE ACCIDENT DETAIL FORM

Patient Name: _____ Todays Date: _____ / _____ / _____

Date of Accident: _____ / _____ / _____ State: _____ Time: ____ : ____ am / pm

AUTO INJURY

Were You: ( ) Driver ( ) Passenger ( ) Pedestrian
Were you struck from:( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked
Were there other passengers/drivers in your vehicle: ( ) Yes ( ) No
Did your car strike the others involved:( ) Yes ( ) No ( ) Undetermined
Did the other car strike yours: ( ) Yes ( ) No ( ) Undetermined
As a result of the Accident, were traffic citations issued to you? ( ) Yes ( ) No
Explanation of Accident:
_____
_____
_____

ON-THE-JOB INJURY

How did the injury occur?
_____
_____
_____

Did you report the injury to your foreman or employer: ( ) Yes ( ) No

Employer:_____

Address:_____

OTHER ACCIDENTAL INJURY

Describe the circumstances of the accident (Be Specific)
_____
_____
_____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

__ Headache	__Sleeping Problems	__Light Sensitivity	__Diarrhea	__Neck Pain	__Head too heavy
__Memory Loss	__Cold Feet	__Stiff Neck	__Pins & Needles	__Ears Ringing	__Cold Hands
__Dizziness	__Face Flushed	__Upset Stomach	__Back Pain	__Numb Fingers	__Buzzing Ears
__Constipations	__Nervousness	__Numb toes	__Loss of Balance	__Cold Sweats	__Tension
__Short Breath	__Fainting	__Loss of Smell	__Chest Pain	__Depression	__Fatigue
__Loss of Taste	__Other				

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

Have you lost any days of work? ( ) Yes ( ) No If Yes,_____ / _____ / _____ through_____ / _____ / _____

Patient / Guardian Signature: _____

PERSONAL INJURY / AUTOMOBILE ACCIDENT
CLAIM INFORMATION FORM

Patient Name: _____ Today's Date: _____ / _____ / _____

YOUR AUTO INSURANCE POLICY

Name of Company:_____

Telephone #:_____

Name on Policy: _____

Policy #:_____

Claim #:_____

Claims Representative Name and Telephone #:_____

Do you have Medical Payments Benefits on your policy? ( ) Yes, Amount:$_____ ( ) No ( ) I don't know

THIRD PARTY INSURANCE POLICY

Third Party's Name:_____

Name of Company:_____

Telephone #:_____

Name on Policy: _____

Policy #:_____

Claim #:_____

Claims Representative Name and Telephone #:_____

Please provide your group or individual health insurance information on the initial intake forms.

Patient / Guardian Signature: _____

ASSIGNMENT OF BENEFITS

I hereby assign all healthcare benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including automobile insurance, private health insurance, third party insurance, and any other health/ medical plan, to issue payment check(s) directly to **COMPLETE CHIROPRACTIC, P.C.** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am ultimately responsible for any amount not covered by my insurance or any third party. I understand that this assignment given to **COMPLETE CHIROPRACTIC, P.C.**herein is irrevocable.

_____ _____ / _____ / _____

Patient's / Guardian's Signature Date

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize **COMPLETE CHIROPRACTIC, P.C.** to: (1) release any information necessary to insurancecarriers regarding my injuries and treatments; (2) process insurance claims generated in the course of examination ortreatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.This order will remain in effect until revoked by me in writing.

_____ _____ / _____ / _____

Patient's / Guardian's Signature Date

ASSIGNMENT, LIEN, RELEASE & POWER OF ATTORNEY

THIS AGREEMENT, entered into this date and between _____ called "PATIENT" and COMPLETE CHIROPRACTIC, P.C..

WHEREAS Patient desires to receive chiropractic services from **COMPLETE CHIROPRACTIC, P.C..,** and desires to assign certain rights and benefits to **COMPLETE CHIROPRACTIC, P.C.** as consideration for **COMPLETE CHIROPRACTIC, P.C.** awaiting payment of such benefits.

Accordingly, it is hereby agreed:

A. Patient hereby authorizes **COMPLETE CHIROPRACTIC, P.C.** to furnish a full report and records regarding case history, examination, diagnosis, treatment and prognosis, x-rays, laboratory reports and the results of all tests of any type or character of patients such persons as **COMPLETE CHIROPRACTIC, P.C.** deems appropriate.

B. Patient's assigns to **COMPLETE CHIROPRACTIC, P.C.** any and all benefits payable by Patient's insurance or health care plan(s) as a result of charges incurred by Patients for services rendered by **COMPLETE CHIROPRACTIC, P.C.**. Patient also assigns to **COMPLETE CHIROPRACTIC, P.C.** any and all contractual rights Patient has against insurance company, health care benefit plan, or any other party possibly liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by **COMPLETE CHIROPRACTIC, P.C.**.

C. Patient fully understands that Patient is directly and fully responsible to **COMPLETE CHIROPRACTIC, P.C.** for all bills submitted for services rendered and that this agreement is made solely for additional protection and consideration for awaiting payment. Patient further understands that such payment is not contingent on any settlement, claim, judgment, or verdict which Patient may eventually recover. In the event of non-payment by any insurance company, health care benefit plan, or any other party possible liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by **COMPLETE CHIROPRACTIC, P.C.**, Patient agrees to be responsible for any such outstanding balance, including interest at a rate 9%, reasonable attorney's fees and costs.

D. Patient fully understands that the lien and assignment given to **COMPLETE CHIROPRACTIC, P.C.** herein is irrevocable.

E. By executing this agreement, Patient hereby instructs and directs any attorney-representing Patient to honor the above lien and assignments and make payment under the lien and assignment directly to **COMPLETE CHIROPRACTIC, P.C.**. Patient directs that attorney be bound by this lien and treat it, irrevocably, as an assignment due to **COMPLETE CHIROPRACTIC, P.C.**. **COMPLETE CHIROPRACTIC, P.C.** is relying upon this lien, assignment and directive to any attorney, and as a result of such reliance, **COMPLETE CHIROPRACTIC, P.C.** is providing care and treatment for which this lien, assignment and directive provides security for payment. *Moreover,* Patient agrees that **COMPLETE CHIROPRACTIC, P.C.** is to be viewed as a third party beneficiary of this direction to Patient's attorney and it is Patient's intent to impose upon Patient's attorney an obligation to comply with the terms of this directive.

F. Patient hereby directs all insurers and other persons possibly responsible for Patient's healthcare costs to make all payments for healthcare services rendered by **COMPLETE CHIROPRACTIC, P.C.** directly to **COMPLETE CHIROPRACTIC, P.C.**.

G. Patient agrees that in the event Patient receives any check, draft, or other payment subject to this agreement, Patient agrees to act as fiduciary agent for **COMPLETE CHIROPRACTIC, P.C.** and will immediately deliver said check, draft, or payment to **COMPLETE CHIROPRACTIC, P.C.** to be applied to Patient's debt for services rendered.

H. Patient hereby appoints **COMPLETE CHIROPRACTIC, P.C.** as Patient's true and lawful attorney, irrevocable, and with full power of substitution, for Patient and in Patient's name, to ask, demand, sue for, collect, endorse, sign and receive proceeds from insurance, other health benefits, and third party claims relating to services rendered to Patient by **COMPLETE CHIROPRACTIC, P.C.COMPLETE CHIROPRACTIC, P.C.** is not obligated or compelled to exercise such powers but may do so in **COMPLETE CHIROPRACTIC, P.C.'s** sole discretion. Patient agrees to fully cooperate with **COMPLETE CHIROPRACTIC, P.C.** in collecting said amounts.

COMPLETE CHIROPRACTIC, P.C. agrees to submit a copy of this agreement with the initial claim form(s) which **COMPLETE CHIROPRACTIC, P.C.** submits to third party payor(s) as notice to the third party payor(s) of the assignment and other agreements contained herein. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in Patient's file and may be picked up by the Patient, upon reasonable request and during normal business hours, or upon written request by Patient, be mailed to designated address.

I. Patient hereby authorized **COMPLETE CHIROPRACTIC, P.C.** to receive a complete copy of Patient's insurance policy, including any endorsements, conditions, limitations or exclusions.

J. A copy of these documents shall be as binding as the document bearing the original signatures.

Patient's or Guardian's Signature: _____ Date: ___ / ___ / ___

Complete Chiropractic, P.C. :_____ Date: ___ / ___ / ___

REFERENCES:

Valley State Bank V. Dean, 97 Colo. 151, 47 P. 2nd 924 (1935*)*
Fort Lupton State Bank v. Murata, 626 P.2d 757 (Colo. App. 1981)
Barcucas v. Bohemia Import Co., Inc., 518 P.2d 850 (Colo. App. 1974)
Thomas v. Oken, 699 P2d (Colo. App. 1984)

CREDIT GUARANTEE
AUTO INSURANCE ASSIGNMENT

PERSONAL BALANCES

INSURANCE ASSIGNMENT

Our Auto Insurance Assignment Program is designed to render you immediate care and keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your insurance carrier on your behalf and wait up to 6 months for payment. Please remember, however, that you are ultimately responsible for payment. As a prerequisite, we ask that you provide a credit card to guarantee payment of your bill and that you provide us with the following:

Your complete automobile insurance information
Your family health insurance plan information

FILING PROCEDURE

We will periodically submit claims on your behalf to both your automobile and health insurance carriers.Any overpayments resulting in credit balances will be refunded promptly at the conclusion of your care.Balances not paid within 6 months after conclusion of your care will be charged to your designated credit card below. You will be sent a payment voucher. Should settlement be reached prior to the 6 month grace period or should care be terminated for any reason prior to your physician dismissal all balances become due immediately, will be charged to your credit card and are subject to monthly interest charges.

CREDIT CARD: VISA or MASTERCARD (circle one)

CARDHOLDER NAME: _____

CARD #: _____ EXP. DATE: _____ / _____ / _____

I agree to the above terms and authorize you to bill my credit card. I understand that should payment not be received within 6 months after termination of my care or should I terminate care before being dismissed by my physician, I will be charged the amount outstanding on my account.

Signature: _____Date: _____/ _____ / _____