caring
CHIROPRACTIC

ASSIGNMENT OF BENEFITS

I, _____, the insured and/or beneficiary of the policy of policies of

_____ Insurance Company providing medical benefits to me, do hereby authorize you to pay directly to **CARING CHIROPRACTIC, D.C./FRANK J. CIALA, DC**, medical provider, benefits due me out of the indemnity under the terms of the applicable policy/policies issued by your company:

Payment is authorized upon receipt of the itemized statement for the services rendered. This policy was in full force and effect at the time services were rendered. I also authorize the above medical provider to obtain counsel and enter legal or other action on my behalf and/or in my name to collect such sums due it, should sums not be paid within the legally prescribed, or within a reasonable period of time. I do hereby promise full and complete cooperation with any legal counsel obtained by the medical provider, including attempting any type of Deposition, Arbitration, or Court proceeding. I understand that if I fail to cooperate with legal Counsel, I may be held personally responsible to the medical provider for any expenses not covered by this assignment. Payment, in whole or in part shall be considered the same as if paid by your company directly to me. A photocopy of this assignment shall be valid as the original.

I hereby agree and acknowledge that I may receive benefit checks directly from the insurance carrier for services rendered by the provider. I hereby agree to immeadiatly forward said checks to the provider upon receipt of the same. It is understood and agreed that should I not forward any benefits to the provider, the provider does maintain the right to request checks from me and initiate any and all collection efforts. If such action is taken by the provider, I agree to be responsible for any and all benefit checks received, plus any and all collection costs incurred including attorney fees and Court costs.

I irrevocably assign to above company or provider all rights and benefits under any insurance contracts for payment of services rendered to provider. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by provider to be released to provider. I irrevocably authorize provider to file insurance claims on my behalf for services rendered to me. I irrevocably authorize provider to act on my behalf and report any suspected violation of proper claims practices to the proper regulatory authorities.

This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

POLICYHOLDER: _____

CLAIM NUMBER: _____

CLAIMANT: _____

ADDRESS: _____

LEGAL SIGNATURE: _____

PATIENT SIGNATURE: _____

DATE: _____

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ACCIDENT REPORT

Patient Name | Initial Consultation Date | Birth Date

Address | City | State | Zip

Insurance Company

Address | City | State | Zip

Policy # | Employer

Date of Accident | Time

Where did accident occur?

How did accident happen?

How were you hurt?

Were you unconscious?

Where were you taken after the accident?

What was done for you there?

Did you return to work? | If so, when and to what kind of work?

How long were you off work? | What treatments did you receive?

Date of Disability: From To

Name of Doctor:

What medication did you take?

Are you still taking medication? | If so, how often and how much?

Are you still receiving treatments? | If so, what kind and how often?

Have you seen any other doctors? | If so, list names and when they were seen:

What were you told was wrong with you?

What are your present complaints?

Are you doing the same kind of work you were doing at the time of injury?

If not, state when you discontinued doing your regular work, what you are doing now, and when you started:

Have you ever had surgery? | If so, give date(s) and condition(s):

What illnesses have you had?

Have you had any previous accidents?

If so, state how you were injured, how long you were off work, what treatments you received, and what problems, if any, you have as a result of the injuries:

Attorney Name | Name of Insured

Address | Address

Telephone