Personal Injury/Accident Medical History Intake Form

Referred by:____________________________Account No.:______________________Date:_____________

Full Name: ____

(Mark a ✓ on each that applies)

Gender: ☐ M ☐ F *Marital Status:* ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Age: ______________ Birth Date:___/____/_____ Height ___________ Weight ________________

Address: ____

City:____State:____________ Zip:___________________

Social Security No. ______________________________ Driver's License No.:________________________

Home Phone: (_______) __________________________ Cell Phone: (______) _________________________

Who Referred you: ____

Employer:_____________________________________ Work Phone: (______) ______________________

Email: ____

Insurance / Attorney Information:

Insured's Name: ____
(Last) (First) (Init)

Relation to patient: ______________ D.O.B.: ______________ Soc. Sec. #: _________________

Insurance Company: ____

ID#:_______________________________________ Group #: __________________________________

Do you have MedPay? ☐ Yes ☐ No Were you at fault? ☐ Yes ☐ No

Have you retained an attorney? Yes / No

Your Attorney's Name: ____

Your Attorney's Phone: (___)______________________________ Fax (____) ________________________

Your Attorney's Address: ____

City: ____ State: __________ Zip: _______________

Accident Information:

ASSIGNMENT, LIEN, AUTHORIZATION OF INSURANCE BENEFITS AND POWER OF ATTORNEY

Name of Patient:____ **Date of Accident:** __________________________

I hereby authorize and direct any insurance company and/or my attorney to pay directly ________________such sums as may be due and owing the office for services rendered to me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, or any other insurance benefits obligated to reimburse me or 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 benefits that I may be entitled to and any and all proceeds for any settlement, judgment or verdict which 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 hereby assign all of my interest and rights to PIP benefits, which shall include, but not be limited to the right to file a PIP suit or seek arbitration for PIP benefits relative to treatment by said Office. I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against any insurance carrier that may be liable for payment of PIP benefits, and authorize this Office to prosecute said cause of action either in my name or in the Office's name and further I authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as they see fit. Further, in the event that the within assignment is not consented to by an insurer or in any other manner is held invalid by any party, arbitrator or any other person, I hereby give this Office the power of attorney to bring any arbitration proceeding or suit in my name on my behalf as if I had filed such action myself. I further agree to fully cooperate with regard to prosecuting such action or proceeding.

I understand that I remain personally responsible for the total amounts due to the Office for services, subject to Law. I further understand and agree that this Assignment, Lien, and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option. I further understand and agree should I receive any payments made on my behalf from any insurance company I will endorse the check over to The Georgia Pain & Spine Institute within 30 days of my receipt of same and fully understand that failure to do so will result in collections procedures against me.

I authorize this Office to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien, and Authorization, so long as the request is submitted in writing. I agree that the above mentioned Office is hereby given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor's bill. I further authorize any insurance company and any other physicians who have treated me for this accident to provide this Office with any documentation needed, with regard to the payment of my bills.

Date:______________________________ **Patient Signature:** ____

PATIENT NAME: ____________________

INSURANCE INFORMATION:

Date of Accident: ____________

Ins. Company: ____________________

Policy #: ____________________

Claim #: ____________________

Adjuster's name: ____________________

Phone #: ____________ Fax #: ____________

Benefits available: Policy Limit $____________ PT BEN____________

LAWYER INFORMATION:

Lawyers: ____________________

Address: ____________________

____

Phone: ____________________

Fax: ____________________

Contact Person: ____________________

Spoke With: ____________ Date: ________ Time: ________

To: ___________________________________

____

____

Re: Medical Reports and Doctor's Lien

I authorized the above doctor and/or their authorized representatives to furnish my attorney, any attorney or attorneys who subsequently are either associated with the said attorney or substituted in their place, with a full report of my examination, diagnosis, treatment, prognosis, itemized bill of charges incurred, etc. in regard to the accident in which I was involved on____________________________, and hold the above doctor free and harmless from any liability in such transfer of information.

Out of the proceeds of the settlement and/or judgment in my claim for personal injuries, I hereby assign, set over and transfer to the above doctor such monies due and owing to him or the group for medical, chiropractic, x-rays, physical therapy, supplies and/or laboratory fees rendered to me, either by reason of the above accident or otherwise. I further give to the above doctor a lien on any and all funds received by me or in my behave in association with the settlement or satisfaction of judgment arising from claims presented on my behalf.

I fully understand that I am directly responsible to said doctors/group for all medical bills submitted by them for services rendered to me. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually receive said fee. In the event legal action shall be brought in order to enforce this lien, then the prevailing party shall be entitled to reasonable costs and attorney fees in addition to any judgment rendered. It is acknowledged by the undersigned that this assignment and lien is further consideration for the services rendered by the above doctor in addition to the obligation to pay for the medical services.

Patient's personal injury claim medical payments are hereby assigned and will be paid directly from the insurance company to _________.

Attorney agrees to notify the doctors immediately of the name and contacting information of any attorney substituted in his or her place.

____ ________________________________

PRINT PATIENT NAME DATE

____ ________________________________

SIGNATURE OF PATIENT SIGNATURE OF PARENT/GUARDIAN

ACKNOWLEDGEMENT OF ASSIGNMENT AND LIEN BY ATTORNEY

The undersigned being the attorney of record on his own behalf and on behalf of any other attorney or attorneys who are associated with the undersigned or who are substituted in his stead for the above patient, does hereby acknowledge receipt of a copy of the assignment and lien, and said attorney acknowledges that he/she obligates themselves to the terms of the assignment and lien in consideration for the rendering of medical services to their client by the above doctor and rendering of a report and bill to said attorney. In the event legal action shall be brought in order to enforce this lien, then the prevailing party shall be entitled to reasonable costs and attorney fees in addition to any judgment rendered. A photographic reproduction of this authorization may be used in place of the original. No charges or alterations of the monies billed herein will be accepted unless confirmed in writing by the doctor. Please date, sign and return on copy as soon as possible to the above referenced medical provider of service in order that treatment can continue on the herein contained lien basis.

____ ________________________________

ATTORNEY'S SIGNATURE DATE