MOTOR VEHICLE ACCIDENT AND/OR WORKER'S COMPENSATION INFORMATION

Motor Vehicle Accident/Personal Injury (if applicable)

>**Date of Accident:** ____/____/_____ **What State did the accident occur in:** _____
>Have you reported the accident to your auto insurance company? ○ **Y** ○ **N**
>If yes when? ____/____/_____ Have you filed a PIP or NO FAULT application with your auto insurance carrier? ○ **Y** ○ **N**
>Do you have an open or pending case with them? ○ **Y** ○ **N**
>Were you the driver of the vehicle you were in? ○ **Y** ○ **N**
>Was the vehicle you were in at fault? ○ **Y** ○ **N**
>Have you received any other medical treatment for injuries related to this accident? ○ **Y** ○ **N**

Your Auto Insurance Carrier's Name: _____ Policy #_____

Claim Number# _____

Adjuster's Name: _____ Phone # _____

3rd Party Auto Insurance Carrier's Name: _____ Policy #_____

Claim Number# _____

Adjuster's Name: _____ Phone #_____

Do you have an attorney? ○ **Y** ○ **N** If yes, Name and phone # _____

If no, would you like for us to recommend one? ○ **Y** ○ **N**

Worker's Compensation (if applicable)

Date of Injury: ____/____/_____ **State the accident occurred in:** _____

Have you or your employer filed a claim? ○ **Y** ○ **N** If yes, When? ____/_____/_____

Is your case open/pending? ○ **Y** ○ **N** Name of Physician who Referred you for Chiro/PT : _____

Worker's Comp Insurance Carrier Name _____ Phone # _____

Claim #: _____ Adjuster's Name _____Phone #_____

Do you have an attorney? ○ **Y** ○ **N** If yes, name and phone # _____
If no, would you like for us to recommend one? ○ **Y** ○ **N**

By signing below I confirm that the information provided above is true to the best of my knowledge. I understand that I may be billed administrative and filling fees for withholding information as it relates to my medical history or insurance coverage.

I understand that Sport and Spine Rehab / Kaizo Health will submit claims on my behalf to the appropriate insurance carriers using the information I have given them. I am aware that it if my treatment is related to an auto accident or work comp injury it is my responsibility to also adhere to the guidelines of my Major Medical insurance so that in the event my personal injury case closes, my health insurance will be billed and I will be responsible for any co- payments, deductibles or non-covered services.

Print Name_____ **Signature**_____ **Date** _____
(Parent/Guardian if patient is a minor)

Witness Signature _____ **Date**_____

PIP INFORMATION - Attorney fills out this box

if available please provide PIP info for your client

Car Insurance (PIP) carrier name: _____

Claim # _____

Adjuster's Name:_____ Phone #:_____

AUTHORIZATION AND ASSIGNMENT

Patient (or legal guardian) fills out this section

I, _____ hereby authorize Sport and Spine Rehab/Kaizo Health and any of its affiliate companies to furnish, upon request, to my attorney, _____ whose signature appears below, copies of medical copies of medical reports of examination, diagnoses, treatment, prognosis, etc. pertaining, but not necessarily limited to my condition resulting from injuries sustained on _____. I hereby irrevocably authorize and direct said attorney receiving such medical reports to pay my physician's charge for services rendered by them, or any balance thereof, which shall include their charge for attendance in court, if required as an expert witness whether they testify or not, and for reports made of depositions given in this matter. Unless the Sport and Spine Rehab/Kaizo Health doctor is instructed otherwise, they will assume that a narrative report is expected upon my release from their care. Said payment is to be made from any monies received by said attorney as a result of compromise or by way of collection of a judgment on my claim for injuries sustained on the above date. Payment of this amount as herein directed shall be the same as if paid by me. This authorization to pay my physician shall constitute and be deemed as assignment of so much of recovery as shall cover the aforesaid bill. I am also authorizing my PIP to be mailed and paid directly to my physician Sport and Spine Rehab/Kaizo Health. I also authorize Sport and Spine Rehab/Kaizo Health to file for and collect their fees through either my health insurance and/or Personal Injury Protection Insurance if and when available. In the event my Personal Injury Protection coverage is paid directly to me, I agree to pay Sport and Spine Rehab/Kaizo Health immediately from these proceeds, with this bill taking precedence over any other financial demands which may have arisen as a result of this accident. I understand that payment to my physician for professional services is not to be delayed during the pendency of my claim. In the event of any dispute as to the charge for services rendered, I hereby authorize and direct my attorney to withhold the full sum claimed by my physician until such time as the matter is settled by compromise or judgment. It is agreed that nothing herein relieves me of the primary responsibility and obligation of paying my physician for the services rendered, and that payment by me for said medical services is not contingent upon any settlement, judgment, or verdict by which I may eventually recover said fee. In the event that my claim has not been settled within 180 days of my release from Sport and Spine Rehab/Kaizo Health, I agree to pay any remaining balance due on my account in full at that time.

PLEASE PRINT NAME CLEARLY

PLEASE PRINT ATTORNEY'S NAME

DATE OF ACCIDENT

_____ _____

Signature Date

_____ _____

Witness Date

ATTORNEY FILLS OUT THIS SECTION

I, _____, accept the above assignment and agree to observe the terms set forth, and to withhold such sums from my settlement, judgment, or verdict as may be necessary to adequately protect Sport and Spine Rehab/Kaizo Health interest.

_____ _____

Attorney's Signature Date

Sport and Spine Rehab
Wintergreen Plaza
827 E Rockville Pike
Rockville, MD 20852
303.251.2777

Sport and Spine Rehab of McLean
6845 Elm Street, Ste 425
McLean, VA 22101
703.448.5799

Metro Sport and Spine Rehab
Metro 400 Building
4301 Garden City Drive, Ste 104
Landover, MD 20785
301.577.1115

Sport and Spine Rehab of Fairfax
3925 Chain Bridge Road, Suite 101
Fairfax, VA 22030
703-890-2222

Sport and Spine Rehab of Fort Washington
9300 Livingston Road
Fort Washington, MD 20744
301.203.6734

LIEN LETTER

_____

_____

_____
(Insurance Company Name and Address)

RE: Claim Number _____

Dear _____,
(Adjuster's Name)

This letter is in reference to _____, who is a patient of Sport and Spine
(Patient's Name)
Rehab/Kaizo Health. In order to receive payment for all medical bills, Sport and Spine Rehab would like to place a lien for all services rendered relating to the patient's injury date of _____. We would like payment send directly
(Date of Accident)
to Sport and Spine Rehab/Kaizo Health. Enclosed is a copy of the patient's Authorization and Assignment form authorizing payment.

I, _____, authorize _____ to forward payment directly
(Patient's Name) (Insurance Company)
to Sport and Spine Rehab/Kaizo Health at the following address: Sport and Spine Rehab/Kaizo Health, 9300 Livingston Road, Fort Washington, MD 20744. You may contact the Patient Service Center at 240-766-0300.

If _____ will not pay SSR directly, I, _____, understand
(Insurance Company) (Patient's Name)
that the 3rd party insurance company will pay me directly and it will be my responsibility to pay my balance in full, not to exceed 90 days after the date that I am discharged from care at Sport and Spine Rehab/Kaizo Health. If I do retain an attorney at any time, or if anything changes with my case that would prevent my payment in full within 90 days, I will notify Sport and Spine Rehab/Kaizo Health immediately.

Sincerely,

_____ _____

Patient Signature **Witness**

Date _____ **Date** _____

PIP Authorization and Assignment

I understand that I am personally responsible for the payment of services rendered to me byKaizo Health/ First Choice Physicians LLC t/a Sport & Spine Rehab, Greenstein and Associates DC t/a Metro Sport & Spine, Sport & Spine Rehab of McLean, Sport & Spine Rehab of Ft. Washington, or Sport & Spine Rehab of Fairfax and Staff. In the event that I have insurance, **I hereby assign the benefits that I am eligible to receive for the care rendered in this office.**

I authorize Kaizo Health/First Choice Physicians LLC t/a Sport & Spine Rehab, Greenstein and Associates DC t/a Metro Sport & Spine, Sport & Spine Rehab of McLean, Sport & Spine Rehab of Ft. Washington, and Sport and Spine Rehab of Fairfax to release any information to any insurance company, adjustor, or attorney that will assist in payment of the claim. I fully understand and agree that the insurance policies are in agreement between the insurance carrier and myself. Any balance due after insurance, payment will be promptly paid by me. If I am uninsured, or choose not to use my insurance, I will be wholly responsible for the bill.

I hereby authorize my insurance company to remit payment directly to:

Sport and Spine Rehab/Kaizo Health of _____
_____
_____

For Medicare: I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits to be made to Kaizo Health/First Choice Physicians LLC t/a Sport & Spine Rehab, Greenstein and Associates DC t/a Metro Sport & Spine, Sport & Spine Rehab of McLean, Sport & Spine Rehab of Ft. Washington, or Sport & Spine Rehab of Fairfax, on my behalf. I give my permission for evaluation and treatment by Kaizo Health/First Choice Physicians LLC t/a Sport & Spine Rehab, Greenstein and Associates DC t/a Metro Sport & Spine, Sport & Spine Rehab of McLean, Sport & Spine Rehab of Ft. Washington, Sor port & Spine Rehab of Fairfax and its staff.

It is further understood that the statute of limitations is three (3) years from the time said services were last performed and I further understand that, because of long delays in trial dockets, many cases are not tried of settled until a date which is beyond three (3) years after the last service was performed. In view of this, I hereby agree that the statute of limitations with respect to any claim for services mentioned above will not begin to run until there is denial in writing by me of the balance claimed to be due to you by me.

In the event there is a breach of this agreement, I understand that I will be responsible for any expenses relating to the collection of my accounting including but not limited to: services and administration charges, legal fees, and/or interest accrued.

I hereby state and agree that photocopy of this document will be deemed valid and binding on all parties involved as the original. This is a direct assignment of my rights and benefits under this policy.

_____ _____
Date Signature (Parent or Guardian If a Minor)

_____ _____
Witness Policy Holder

Graded Symptom Checklist

Name: _____ Date: _____ Date of Injury: _____

Instructions: Indicate how much each symptom has bothered you in the ***last 48 hours, or since the time of your injury***

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Blurred/Visual Problems	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
	Ringing in Ears	0	1	2	3	4	5	6
Thinking	Easily Distracted	0	1	2	3	4	5	6
	Feeling Mentally Foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	0	1	2	3	4	5	6
	Difficulty Concentrating	0	1	2	3	4	5	6
	Difficulty Remembering	0	1	2	3	4	5	6
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping Less/Disturbances	0	1	2	3	4	5	6
	Sleeping more than Usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotional	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more Emotional	0	1	2	3	4	5	6
	Personality Changes	0	1	2	3	4	5	6
Other (please describe below)		0	1	2	3	4	5	6

Total Score =							

Did you lose consciousness due to your accident? □ Yes □ No

Did your sustain a blow to the head? □ Yes □ No

Location of impact □ Frontal □ Left Temple □ Right Temple □ Top of Head □Back of Head

Do any of the above symptoms worsen with,

Physical Activity □ Yes □ No □ Not Applicable

Thinking/School/Work/Cognitive Activity □ Yes □ No □ Not Applicable

Over the past 2 days, what percent of your daily activity level is normal? _____%