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**______________________

NOTICE: AUTOMOBILE ACCIDENT PATIENTS

If you have been in an automobile accident, you may be entitled to payment from your automobile insurance if you have medical expense benefits coverage. By signing this assignment of benefits form, you are giving to your health care provider the right to receive some or all of the payment directly from your automobile insurance company.

If you do not provide the information necessary to verify your health insurance coverage, do not have health insurance, or your healthcare provider is not in your health insurer's provider network, your healthcare provider may bill its full charges to your automobile insurance.

You may want to consult your insurance agent or attorney before signing or initialing this form. You are not required to sign/initial this form to receive care. **However, if you do not sign this form, you will be required to (i) pay any applicable co-pays and deductibles at the time the services are provided and allow us to bill your health insurance company or (ii) pay for all care at the time of service.**

By signing below, I acknowledge that I have read or had the opportunity to read this notice.

Print Patient's Name: ______________________________

Patient's Signature: ________________________________

Signature of Parent or Guardian if patient is a minor ___________________________

Date: ____________________

IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORIZATION AND LIEN

To Whom It May Concern:

This Irrevocable Assignment of Benefits, Authorization and Lien (this "Assignment") is made by and between ______________________________ ("Patient") and _________________________ ("Health Care Provider"). With this Assignment, and in consideration of treatment without having to render concurrent payment, Patient, hereby irrevocably transfers sets over and assigns to Health Care Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the Patient by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorney's fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to Patient or on Patients behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, personal injury protection benefits, third-party liability coverage, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patients favor as may be necessary to fully pay any and all financial obligations owed to the Health Care Provider by the Patient. This Assignment is to be a complete and current transfer of Patients right, title, and interest, separate from any statutory or contractual lien or claim to which the Health care Provider may also be entitled. Patient acknowledges that Health Care Provider has a substantial pecuniary interest in the enforcement of this Assignment.

The Patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Providers total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Health Care Provider any and all causes of action that Patient might have or that might exist in Patients favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates and appoints as Patients attorney-in-fact any officer of Health Care Provider, to prosecute said causes(s) of action either in Patients name or in the Health Care Providers name and Patient further authorizes the Health Care Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Health Care Provider, Patient hereby grants a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Health Care Provider. The Patient further agrees that the statute of limitations applicable to Health care Providers right to demand payment from the patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing.

Patient hereby acknowledges that Virginia law imposes a lien in the amount of $750.00 upon Patients claim against the individual or entity whose negligence is alleged to have caused Patients injuries.

Notwithstanding the foregoing, the Patient agrees that until the Health Care Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due the Health Care Provider (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The Patient further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect payment, it may demand payments from Patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

Patient authorizes the Health Care Provider to release this Assignment and any information pertinent to Patients case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Health Care Provider as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of the services provided to Patient by said Health Care Provider.

In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect.

Notice regarding the assignment of medical expense benefits is provided in a separate document. I have been presented with and had an opportunity to read the notice. Acknowledged:_________(patient initials)

Witness the following signatures and seal as of the indicated date:

Patient

Patient's Signature________________________________

Printed Name___________________________________

Date_____________ SS#______________________

Witness___________________________

Attorney ___________________________ Date: _____

Health Care Provider

Sport and Spine Rehab/Kaizo Health

By: Dr. Jay Greenstein

It's Owner

Date: 6/28/2013

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, ______________________ (PLEASE PRINT NAME CLEARLY) hereby authorize Sport and Spine Rehab/Kaizo Health and any of its affiliate companies to furnish, upon request, to my attorney, _________________________ (PLEASE PRINT ATTORNEY'S NAME) 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 ________________ (DATE OF ACCIDENT). 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.

______________________________ ______________________
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

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? _______%