Dr. James Moore- Harpeth Chiropractic Center

To our valued patient,

We are truly sorry for the circumstances that have brought you to our office today. Our focus is providing you the best possible care so that you can recover as quickly as possible. To properly handle the billing of your case, it is essential you complete the forms attached and we have the following documents to proceed:

- Driver's License
- Your Auto Insurance Card and Declaration Page listing coverage
- At-Fault Party Insurance Information
- Attorney Information (if any)
- Accident/Incident Report

BMW Case Management, LLC will be handling your Personal Injury file. They are contracted by our office to ensure all documentation and necessary items are in place. They are also contracted to be patient advocates to ensure that you are educated and guided through this process. Your health is very important to us and we want to make sure you are taken care of.

PLEASE MAKE SURE YOU COMPLETELY ANSWER EVERY QUESTION, FILL IN EVERY BLANK AND BE SURE TO SIGN OR INITIAL EVERY SPACE THAT ITS REQUIRED. THESE FORMS ARE GOING TO BE ESSENTIAL WHEN IT COMES TIME TO SETTLE YOUR CASE OR IF YOU NEED TO OBTAIN AN ATTORNEY.

As you leave the office you will be given an information packet from BMW Case Management, LLC. Please contact their office within 24 hours of your first visit.

Thank you,

Dr. James Moore and Staff

Dr. James Moore - Harpeth Chiropractic Center

PERSONAL INJURY/AUTOMOBILE ACCIDENT FINANCIAL POLICY

Our Personal Injury/Automobile Insurance Assignment Program is designed to provide you immediate care and keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your auto insurance carrier on your behalf. 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. You must notify us if you retain an attorney.

(initial) _____

PERSONAL INJURY PROTECTION

"Personal Injury Protection" or "PIP" is part of your own auto insurance policy which will immediately cover the costs of your medical expenses billed by a licensed health care provider for you and any passengers in your vehicle, up to a certain limit, regardless of fault. PIP benefits are customary on all auto insurance policies. If payment is made by this method, and you are not at fault, your insurance premiums may not increase. Med-Pay is a benefit that covers treatment for injuries sustained during a motor vehicle accident. We require you to use your "Med-Pay" if it is available on your policy.

(initial) _____

AT FAULT

Tennessee is an "at-fault" state. The "at-fault" insurance company is responsible for any outstanding balances due to medical treatment resulting from a personal injury or motor vehicle accident. 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. These claims will only be considered for payment when treatment is complete, and you are released from care. At this time, a settlement will be reached between you and the third party which will include a pain and suffering award once a release of liability agreement has been signed by both parties.

(initial) _____

HEALTH INSURANCE

We will ***NOT*** bill your personal health insurance for any services pertaining to this personal injury or motor vehicle accident. However, we do require health insurance information to be on file for continued care after settlement of this case.

(initial) _____

FINANCIAL RESPONSIBILITY

I, _____ understand that I am primarily responsible for all medical bills for treatment from the motor vehicle accident. Dr. James Moore agrees not to demand payment at the time of service, and I agree to pay Dr. James Moore from the proceeds of any motor vehicle accident. Should I, my insurance company, third party insurance company or attorney fail to pay Dr. James Moore from the proceeds, I agree to pay all court costs, collection costs and attorney fees associated with the delinquent account.

(initial) _____

I have read and understand the personal injury/automobile accident financial policy of Harpeth Chiropractic Center. I understand that I am ultimately responsible for any services rendered to me by Harpeth Chiropractic Center. I understand that if I terminate care outside my doctor's recommendations, any balances will be due immediately.

_____

Patient Name

_____ _____

Patient or Guardian Signature Date

Doctor's Lien

Dr. James Moore-Harpeth Chiropractic Center

Patient's Name:_____ Date of Birth: _____

I do hereby authorize Dr. James Moore to furnish a full report of his examination, diagnosis, treatment, prognosis, etc., to all parties involved regarding this motor vehicle accident.

I hereby authorize and direct my insurance company, responsible party's insurance company and/or my attorney to pay directly to said doctor such sums as may be due for medical service rendered to me both by reason of settlement, judgment, or verdict as may be necessary to adequately protect said doctor. I hereby further give a LIEN on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to my attorney, or directly to said doctor as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

(initial) _____

The undersigned does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, third-party settlement, judgment, or verdict as may be necessary to adequately protect said doctor above named.

(initial) _____

By signing below, I understand and agree that in the event of default, I am legally liable for all costs of collection including collection fees, reasonable attorney fees, court costs, and all other costs related to the collection of debt.

(initial) _____

If my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment. A payment plan will not be offered or accepted and will declare the entire due and payable immediately.

Patient's Name: _____

Patient or Guardian's Signature: _____ Date:_____

_____

Address City St Zip

The undersigned being attorney of record for the above patient do hereby agree to observe all the terms of the above and agrees to withhold such sums form any settlement, third-party settlement, judgment or verdict as may be necessary to adequately protect said doctor named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Attorney Signature:_____ Date: _____

ASSIGNMENT OF INSURANCE BENEFITS AND PROCEEDS OF CLAIM

I am seeking treatment from Dr. James Moore ("the Doctor") for injuries I suffered in a vehicle accident. In consideration of receiving such treatment, I hereby assign to the Doctor the following monies to which I am or may become entitled.

Insurance Benefits. I have an automobile insurance policy issued by _____ Insurance Company. I hereby assign to the Doctor any benefits to which I am or may become entitled under that policy. The amount assigned to the Doctor shall be limited to the amount of the charges for medical services rendered to me by the Doctor as treatment for injuries I received in the accident dated _____20_____.

Proceeds of My Claim Against Another Party. It may be determined at a later time, by a court through litigation or by settlement negotiations between the parties and/or their insurance company representatives, that another party caused the accident in which I was injured and that the other party is therefore responsible for paying damages to me in an amount sufficient to cover, in whole or in part, the medical expenses I have incurred as a result of the accident. If this determination is made through a settlement, the settlement agreement may provide that an amount of money shall be paid to me by the insurance company for the other party, even though the settlement agreement states that the payment shall be made without an admission of liability by the other party.

If the insurance company for the other party agrees to pay, or is ordered by a court to pay, a specified sum to me for bodily injuries I incurred in the accident, I hereby assign to the doctor a portion of the monies I am entitled to receive from the other party's insurance company, limited to the amount of the charges for medical services rendered to me by the Doctor as treatment for injuries I received in the accident.

I understand that I am at this time making an assignment of the proceeds of a potential claim against the other party involved in the accident and that this assignment will be effective only after a determination, either by a court or by a settlement, that the other party's insurance company will pay a specified amount of money to me.

I understand that a copy of this Assignment must be provided to the insurance company for the other party before it will be binding on that company and that the doctor must provide to that insurance company appropriate evidence of the services provided to me and the charges for those services.

By making this Assignment to the Doctor, I am directing _____Insurance Company for the other party and/or my attorney _____to pay the assigned amount directly to the Doctor.

Dr. James Moore- Harpeth Chiropractic Center
8122 Sawyer Brown Rd Ste 206
Nashville, TN 37221

I understand that if the insurance benefits and claim proceeds which are or become available to me are insufficient to cover the charges of the doctor for the medical services provided to me, I am responsible for paying the balance of those charges.

I understand what I have read and agree to this Assignment of Benefits. I further understand that this agreement is irrevocable.

_____ _____

Witness Print Patient Name

_____

Patient or Guardian Signature

Date: _____

ACTIVITIES OF DAILY LIVING

Patient's Name: _____ Date: _____

Carrying Groceries	___No Effect	___ Painful (can do)	___ Painful(limits)	___Unable to Perform
Sit to Stand	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Climbing Stairs	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Pet Care	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Driving	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Extended Computer Use	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Household Chores	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Lifting Children	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Reading/Concentration	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Dressing	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Shaving	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Sexual Activities	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Sleep	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Static Sitting	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Static Standing	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Yard Work	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Walking	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Washing/Bathing	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Sweeping/Vacuuming	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Dishes	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Laundry	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Garbage	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Bending	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Care for Family	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Kneeling	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Other:_____	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Other:_____	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Lifting (weight limit)	Circle one:	10lbs 20lbs	30lbs 40lbs	50lbs

Please mark **P** for "in the **Past**", **C** for "**Currently**" have and **N** for "**Never**"

___ Headache	___ Pregnant(now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds, Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Press.
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Press.
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot/Knee Problems	___ Hearing Loss	___ Menstrual Problems	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Prob	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis(A,B,C)

Dr. James Moore
Harpeth Chiropractic Center
PERSONAL INJURY/AUTOMOBILE ACCIDENT CLAIM INFORMATION FORM

Today's Date _____

Patient Name: _____

Guardian Name: _____

For Office Use Only:

- ☐ Copy of Driver's License
- ☐ ***Signed*** Dr's Lien
- ☐ ***Signed*** Financial Policy
- ☐ ***Signed*** AOB/Settlement
- ☐ Copy of Personal Auto Insurance
- ☐ Copy of Per. Auto Declaration Page
- ☐ At-Fault Auto Info
- ☐ Attorney Info (if any)
- ☐ Accident Report
- ☐ BMW Case Mgt,LLC Business Card to Patient
- ☐ BMW Case Mgt,LLC Intro Letter to Patient

Verified by:_____ Date_____

YOUR Auto Insurance Information

Insurance Company: _____

Telephone #: _____

Name on Policy: _____

Policy #: _____

Claim#: _____

Claims Representative: _____

Claims Representative Phone #: _____

Do you have Medical Payments Benefits on your policy?

- ☐ Yes, Amount: _____
- ☐ No
- ☐ I don't know

Third Party/At Fault Driver Insurance Information

Third Party/Driver's Name: _____

Insurance Company: _____

Telephone #: _____

Name on Policy: _____

Policy #: _____

Claim#: _____

Claims Representative Name: _____

Claims Representative Phone #: _____

Attorney *(it is not always necessary to have an attorney for personal injury claims)*

Name of Law Firm: _____

Name of Attorney: _____

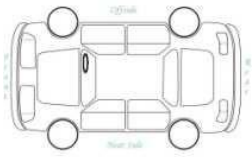
Phone #: _____

Patient / Guardian Signature: _____

Dr. James Moore
Harpeth Chiropractic Center
ACCIDENT HISTORY QUESTIONNAIRE

Patient Name_____Date_____

1. Date of Accident:_____2. Time:_____AM/PM
3. Driver of Car:_____
4. Where were you seated?_____
5. Who owns the car?_____
6. Year & model of your car:_____
   Year & model of other car:_____
7. What was the approximate damage done to your car? $_____
8. Visibility at time of accident ☐Poor ☐Fair ☐Good ☐Other:_____
9. Road conditions at the time of accident:☐Icy ☐Rainy ☐Wet ☐Clear ☐Dark
   ☐ Other(describe)_____
10. Where was your car struck?

FRONT  BACK

In your own words, please describe accident:_____

_____

_____

_____

_____

11. Type of Accident:☐Head-on collision ☐Broad-side collision ☐Non-collision
12. At the time of the accident, recall what parts of your head or body hit what parts on the inside of thecar:_____

_____

13. Did you see the accident coming? ☐Yes ☐No
14. Did you brace for impact?☐Yes ☐No
15. Were seat belts worn?☐Yes ☐No
16. Where shoulder harnesses worn?☐Yes ☐No
17. Does your car have headrests?☐Yes ☐No If yes, what was the position of those headrests compared to your head before the accident?
    ☐ Top of headrest even with bottom of head
    ☐ Top of headrest even with top of head
    ☐ Top of headrest even with middle of neck
18. Was your car braking?☐Yes ☐No
19. Was your car moving at the time of the accident? ☐Yes ☐No
20. If yes, how fast would you estimate you were going?_____mph
21. How fast would you estimate the other car was going?_____mph
22. Head/body position at the time of impact
    ☐ Head turned left/right ☐Body straight in sitting position
    ☐ Head looking back ☐Body rotated right/left
    ☐ Head straight forward ☐Other:_____
23. As a result of the accident, you were: ☐Rendered unconscious ☐In shock
    ☐ Dazed, circumstances vague ☐Other:_____
24. How was the shoulder harness adjusted?☐Loose ☐Snug

25. Were you wearing a hat or glasses? ☐ Yes ☐ No
26. Could you move all parts of your body normally or as you could before the accident? ☐ Yes ☐ No
27. If no, what parts couldn't you move and why? _____
_____
28. Were you able to get out of the car and walk unaided? ☐ Yes ☐ No
29. If no, why not? _____
30. Did you get any bleeding cuts? ☐ Yes ☐ No If yes, where? _____
31. Did you get any bruises? ☐ Yes ☐ No If yes, where? _____
32. Please describe how you felt:
    Immediately after the accident: _____
    Later that day: _____
    The next day: _____
33. Check symptoms apparent since the accident:

☐ Headache	☐ Neck pain/Stiffness	☐ Mid backpain
☐ Eyes Light Sensitive	☐ Pain Behind Eyes	☐ Dizziness
☐ Fainting	☐ Sleeping Problems	☐ Numbness in Fingers
☐ Numbness in Toes	☐ Loss of Smell	☐ Loss of Taste
☐ Loss of Memory	☐ Fatigue	☐ Breath Shortness
☐ Irritability	☐ Depression	☐ Ringing/Buzzing
☐ Loss of Balance	☐ Tension	☐ Cold Hands
☐ Cold Feet	☐ Diarrhea	☐ Constipation
☐ Chest Pain	☐ Nervousness	☐ Cold Sweats
☐ Anxious	☐ Facial Pain	☐ Clicking or Popping Jaw
☐ Low Back Pain	☐ Other _____	

34. Occupation: _____
35. Employer: _____
36. Have you missed time from work? ☐ Yes ☐ No
37. If yes, full time off work: _____ to _____
38. If yes, part time off work: _____ to _____
39. Did you seek medical help immediately after the accident? ☐ Yes ☐ No
    ☐ If yes, how did you get there? ☐ Ambulance ☐ Police ☐ Someone Else Drove Me
    ☐ Drove Own Car ☐ Other: _____
40. Doctor #1: Name: _____
41. First visit date: _____
42. Were you examined? ☐ Yes ☐ No
43. Were X-rays taken? ☐ Yes ☐ No
44. Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars
45. If yes, what kind of treatment did you receive? _____
46. What benefits did you receive from the treatment? _____
47. Date of last treatment? _____
48. Doctor #2: Name: _____
49. First visit date: _____
50. Were you examined? ☐ Yes ☐ No
51. Were X-rays taken? ☐ Yes ☐ No
52. Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars
53. If yes, what kind of treatment did you receive? _____

_____ _____

Patient / Guardian Signature Date