Edwards Chiropractic & Rehabilitation Center
3919 Miller Road
Columbus, Georgia 31909
Telephone (706) 565-9447

Patient_____ Date_____ Date of Injury_____
Claim or File No._____ Policy No._____

Contract for Services/Irrevocable Assignment/Lien & Limited Power of Attorney

This contract allows chiropractic and medical treatment to be performed to said patient without demand for immediate payment of the total amount of the services to be paid at the time of treatment. This allows the balance of the fee for services for treatment in the above mentioned injury to be financed by Edwards Chiropractic & Rehabilitation Center without interest until the settlement of the incident causing the aforementioned injury. In return the patient has bound the attorney in this contract to make full payment for these feel to Edwards Chiropractic & Rehabilitation Center within fifteen (15) days of settlement. If an attorney is not bound, this document attaches a lien and/or irrevocable assignment to any and all settlement payments from and identified insurer immediately upon final agreement and Edwards Chiropractic & Rehabilitation Center.

This document and all that is contained herein is a specifically designed instrument to detail an irrevocable and enforceable contract, lien, and limited power of attorney. This contract entered into on this day of _____, _____ here forth known as the "attorney"or insurance company, and Edwards Chiropractic & Rehabilitation Center known as the "clinic". May it be known that the patient has entered into the contract with representation and is binding upon acknowledgement of receipt by such counsel. The patient, hereby directs the attorney, or any additional counselor or third party insurance company identified within this document, such as may be due owing this office for services rendered to the patient, both by reason of accident or illness, and by reason of any other bills due this office and to withhold such funds from any disability benefits, medical payment benefits, or from any settlement, or judgement or verdict on my behalf as may be necessary to adequate protect Edwards Chiropractic & Rehabilitation Center . I further give an irrevocable assignment attaching any and all insurance benefits named herein. Although liability is not assignable, once the patient has accepted or made agreement with a third party liability carrier the patient can direct and hereby makes such irrevocable declaration that whatever proceeds named in this document for the amount as determined by the medical record and billing of Edwards Chiropractic & Rehabilitation Center be made payable to the clinic and mailed to 3919 Miller Road, Columbus, Georgia 31909.

With contract the patient is personally and jointly with the attorney, if retained, or other noted counsel responsible for the total amounts due to said office. The attorney is only released from this binding contract if there is no settlement of any amount for the above mentioned injury or if the patient acquires new counsel the contract is now binding on the new counsel in its entirety, and if all legal representation in reference to this accident has been terminated prior to settlement with the previous attorney, the previous attorney is therefore released from all aspects of this contract upon written notice received in this office by U.S. mail according to the postmarked date. The patient and attorney understand that not honoring the full extent and purpose of this contract constitutes default and binds upon both parties separately and individually all charges, collection costs, attorney fees, and finance charges. This contract can only be altered with the amount of settlement payment by written sign verification from Edwards Chiropractic & Rehabilitation Center and the bound third party of legal counsel.

The patient authorizes the clinic to release any information pertinent to this injury to the attorney and to any insurance company, adjuster or third party attorney to facilitate collection under this assignment and contract. The patient agrees that the above mention office is given power of attorney to endorse/sign the patient's name on any and all payment made toward the patient clinic bill from any party regardless of their inclusion in the contract.

Patient Signature:_____ Date:_____
Witness:_____ Attorney of Record:_____

The Original Document to be retained in the clinic.
Attorney Signature:_____ Date:_____

Statement, Assignment, Truth & Liability
(Please read and initial in each blank)

I confirm that all the information recorded in this form is true and complete to the best of my ability._____

I also understand that all services rendered to me are charged directly to me, and I am personally responsible for payment._____

I understand and agree that health and auto insurance Med-Pay policies are contracts between an insurance company and me._____

I hereby authorize and direct assignment of benefits under this arrangement that any Med-Pay, Third Party Insurer, or health insurance make payment for my chiropractic treatment directly to Edwards Chiropractic & Rehabilitation Center and understand this is an irrevocable assignment and lien._____

I further understand that Edwards Chiropractic & Rehabilitation Center will prepare forms to assist me in making collection from my insurance carriers. I understand that any amount paid directly to Dr. Marcus Edwards or Edwards Chiropractic & Rehabilitation Center by my insurance company will be credited to my account upon receipt._____

If I suspend or terminate my care at this office, any and all outstanding charges for professional services rendered by me will become immediately due and payable._____

I understand that any monies sent directly to me or obtained by me for this accident should be used to pay for treatment must be as such. If any payments are not surrendered to the clinic within 3 days, the entire bill may become immediately due and may be sent to collections with a 30% collection fee at the discretion of the clinic._____

Patient Signature:_____ Date:_____

Print Name (Last, First, MI)_____

Witness of Signature_____

If under 18 years of age: As legally appointed guardian/parent of _____ . I hereby authorize Dr. Marcus Edwards and Edwards Chiropractic & Rehabilitation Center to treat the aforementioned minor and accept full responsibility of any changes generated thereby. I agree to the statement of assignment, truth and liability.

Guardian Signature_____ Date:_____

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We Appreciate Your Referrals !!

Auto Accident Only:

Description of the Auto Accident - Check the appropriate description - please check all that apply!

Please circle descriptions in parenthesis that apply. " (n) "

___I was (Stopped/ Slowing down/ Accelerating) for a (traffic light/ traffic/ stop sign) and was struck in the rear by another car.

___I was pushed into another vehicle

___While slowing down to execute a turn, was struck in the rear by another vehicle.

___Was sideswiped by a vehicle traveling in the (same direction / opposite direction).

___Was involved in a head on collision.

___Another vehicle made an improper turn and caused the two vehicles to collide.

___A vehicle ran a (red light / stop sign) striking me in the (front / rear / side).

___After being hit, the vehicle spun around.

___After being hit the car rolled over.

___I was involved in a multi-car collision.

___The driver lost control of the car and hit _____ .

Please write Y for YES , and N for NO .

___ Were you thrown from the car?

___ Did the seat back break?

___ Were you wearing a seat belt?

___ Were you a pedestrian? Describe:_____

___ Other:_____

Did you strike any object in the car (Y ? N) _____ (Below write the body part that struck the object in the blank ie: _head_ Wind shield)

_____ Wind shield _____ Rear Window _____ Headrest _____Dashboard _____Side Window

_____ Steering Wheel _____ Door Window _____ Rear View Mirror _____ Cannot Remember

Were you: Knocked Unconscious?_____ Cut & Bleeding? _____ Badly Bruised? _____

What pain did you feel immediately after impact? (Circle) None Head Neck Shoulders Arms (L or R) Hand (L or R) Upper Back Mid Back Lower Back Hips Legs Knee (L or R) Ankle (L or R) Foot (L or R) Chest Stomach Other_____

What pain did you feel several hours after the accident: (circle) None Head Neck Shoulders Arms (L or R) Hand (L or R) Upper Back Mid Back Lower Back Hips Legs Knee (L or R) Ankle (L or R) Foot (L or R) Chest Stomach Other_____

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Please Answer The Following Questions

What did you do after the accident? ___ Went Home and Took It Easy ___ Went About Normal Business ___ Went Home & doctored self with OTC drugs thinking the pain would go away? ___Was taken to the hospital by ambulance ___Was driven or drove self to hospital ___ Went to Regular Physician ___ Went directly to the Chiropractor .

Date and Time you arrived to the Emergency Room:_____
Were You Admitted? ☐ YES ☐ NO Name of Hospital:_____

What happend in the Emergency Room? (Circle) Examination X-Rays (neck upperback lowerback chest other_____
Prescription:_____
Injection Stitches Physiotherapy Cervical Collar Wounds dressed Cast/Brace Supplied
MRI CT Scan CAT Scan Other:_____

What did the hospital tell you?_____
_____

Following your released from the hospital, what did you do? ___Returned home and took it easy ___Returned to the emergency on _____. ___Returned to work.

Please Read Carefully

Did you consult another physician after the emergency room? ☐ YES ☐ NO
If so, who?_____
When? _____
What did they tell you?_____
What treatment was done? (circle) Examination X-Rays (neck, upperback, lowerback, chest, other_____
Prescriptions:_____
Injections Stitches Physiotherapy Cervical Collar Wounds dressed Cast/Braced Supplied
MRI CT Scan CAT Scan Other:_____

Did you consult another physician or therapist after that? ☐ YES ☐ NO if so who?_____
When did you receive your consultation?_____ What did they tell you?_____
What treatment was done: (circle) Examination X-Rays (neck, upperback, lowerback, chest, other_____
Prescriptions:_____
Injection Stitches Physiotherapy Cervical Collar Wounds dressed Cast/Brace Supplied
MRI CT Scan Cat Scan other:_____

How long did you see these doctors?_____
Are you still under the doctor's care?_____
When were you discharged?_____
Have you had an independent medical examination?_____

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Have you ever had to limit your activities? ☐ YES ☐ NO if yes, how?_____

Have you lost days from work? ☐ YES ☐ NO
Describe in Detail (give dates if possible)_____
_____

Are you still off from work? ☐ YES ☐ NO

Are you currently employed? ☐ YES ☐ NO

Are you working with restrictions? ☐ YES ☐ NO If yes, describe:
_____
_____

Who prescribed the restrictions?:_____

What dates do the restrictions cover?:_____

Additional Comments or
Concerns:_____
_____

Isn't this the most ridiculous form you have filled out since the accident?: ☐ YES ☐ NO

Have you obtained an attorney: ☐ YES ☐ NO

If yes, Who? _____

Address: _____

Phone #: ( ) _____ - _____

Signature:_____ Date:_____.