

ERICKSON CLINIC OF CHIROPRACTIC
3000 Bethesda Place, Suites 401-402
Winston-Salem, NC 27103
Phone: 336 760-1333
Fax: 336 760-9111

Personal Injury Financial Agreement

I, _____, the undersigned, accept financial responsibility for my care provided by the Erickson Clinic of Chiropractic. To this end, I agree to make per visit payments of \$10.00. (Minimum of \$10 per visit / If we are filing health insurance, we are contractually obligated to collect any deductibles, co-payments or co-insurance at the time of service.) In the event that my case has not settled one month after the date of my last visit, I agree to make monthly payments of \$150.00 until my balance is at zero and paid in full. I understand that it is my responsibility to notify the Erickson Clinic of Chiropractic of any changes regarding my personal injury case. Failure to notify can be constituted as default. Any action deemed appropriate may be undertaken to recover unpaid balances, upon determination of default of this agreement.

Upon my release from care or the discontinuance of care at the Erickson Clinic of Chiropractic, I agree to continue making payments towards my account balance as detailed in this financial agreement.

Witness

Patient

(Sealed)

Date

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Personal Injury Insurance Information

Your Auto Insurance Company _____ Policy # _____

Insured's Name _____ Adjuster _____

Medical Payments Coverage: Yes No

Address/Phone _____

Policy/ID # _____ Insured's Name _____

Other Driver's Insurance _____ Policy # _____

Insured's Name _____ Adjuster _____

Address/Phone _____

Your Attorney _____ Phone _____

We request that you sign an Authorization/Assignment form, which allows us to bill the insurance company directly. If you do not wish to sign the Authorization/Assignment form, payment is required at time of service. We will bill your auto insurance company, the other driver's insurance, and your attorney will receive an itemized statement and report regarding your accident/injury.

If you do not have an attorney, then a claim will be filed with the other driver's insurance company. Any balance due is your financial responsibility. Any over-payment will be reimbursed to you. I have read, and I understand the above statements concerning the submission of bills regarding my care.
_____ (please initial)

AUTHORIZATION AND ASSIGNMENT OF BENEFITS:

(X) I hereby authorize Drs. Rick and Megan Erickson to furnish all information, which the insurance company may request concerning my present injury(ies).

(X) I hereby assign to Drs. Rick and Megan Erickson all money to which I am entitled for medical expenses relative to their service(s) rendered for my present injury(ies). I understand that I am financially responsible to Drs. Rick and Megan Erickson for all charges not covered by this assignment. (A Photostat copy of this authorization/assignment shall be considered as valid and effective as the original.)

Authorized
Signature _____

(Patient/Spouse/Guardian/Insured)

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Medical Reports and Doctor's Lien

I do hereby authorize Drs. Rick and Megan Erickson, to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctors such sums as may be due and owing him/her for medical service rendered me by reason of this accident and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctors. And I hereby further give a lien on my case to said doctors against any and all proceeds of my settlement, as the result of the injuries for which I have been treated of injuries in the connection therewith.

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

Patient/Guardian/I Signature

Date

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctors above named. In addition, in the event that said patient terminates business with this attorney, attorney will notify said doctors immediately in order for doctors to make other arrangements to protect his/her fee.

Attorney's Signature

Date

Please sign, date and return one copy to our office – keep one copy for your records.

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Personal Injury Financial Policy

We will file the patients personal insurance if applicable and assist in processing claims to the attorney or liability carrier. A liability form must be completed and signed so the medical records can be submitted. We will recoup any amount written off due to filing personal insurance from the liability carrier or attorney.

Personal injury patients, if involved in an automobile accident, **must furnish this office with the following:**

1. Any and all personal Major Medical Health Insurance in which the patient is enrolled.
2. Auto Policy, which shows medical payment benefits.
3. Police Report of the accident.
4. The insurance information of the individual at fault.
5. Attorney's information.
6. Completed Personal Injury Questionnaire and other necessary forms.

Patients will be expected to sign the following forms:

1. Acknowledgement of Assignment
2. Attorney Lien
3. Insurance Forms
4. Office Policy
5. Authorization for Direct Payment
6. Financial Agreement

If any of the above criteria has not been satisfied by the 4th visit I understand that my account status will be changed to cash – with no insurance being filed.

If the patient chooses not to retain an attorney in their case, the patient must sign a Power of Attorney to this office exclusively so that we may ensure direct payment to this office. The patient then should follow our policies for patients with or without insurance. **NO EXCEPTIONS WILL BE MADE.** If you miss two consecutive appointments your attorney will be notified.

If the Doctor or patient chooses to discontinue care and treatment in this office for any reason whatsoever, the balance of the account is due and payable in full at that time. In the event payment for charges incurred in this office are sent to the patient by mistake, the checks should immediately be brought to our office to be applied toward the balance of the account.

I have read and understand the financial policy of the Erickson Clinic of Chiropractic.

Witness

Patient

Date

