Minor
PI

CHIROCAROLINA
537 West Sugar Creek Road, Suite 101
Charlotte, North Carolina 28213

Dr. Henry E. Rice
Dr. Ferzaan A. Ali
Dr. R. Scott Saario

Date of Accident:
_____/_____/_____

New Personal Injury Case
(Please PRINT Clearly)

Today's Date: _____/_____/_____ Chart #: _____

Name: _____
First Middle Last

Address: _____ Apartment #: _____

City: _____ State _____ ZIP _____ Driver's License #: _____

Social Security #: _____ E-Mail Address: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

DOB: _____/_____/_____ Age: _____ Gender: Male_____ Female_____

School: _____

Name of Parent: _____ Parent's SSN: _____

Parent's Employer: _____

Parent's Work or Cell Phone: (_____) _____-_____ Parent's DOB: _____/_____/_____

Previous Chiropractic Care? Yes ☐ No ☐ Doctor's Name: _____

Health Insurance Company: _____(please provide a copy of your insurance card)

Major Complaint: _____

Nearest Friend or relative that can be contacted in case of an emergency: _____

Relationship: _____ Phone #: (_____) _____-_____

It is usual and customary to pay for services as rendered unless otherwise arranged.

I do hereby authorize ChiroCarolina, (Henry E. Rice D.C./Ferzaan A. Ali, D.C./R. Scott Saario, D.C.) to furnish my insurance company with a full report of physical examination, diagnosis, treatment, prognosis, etc. of myself in regard to my injury, if requested by them.

I hereby authorize and direct payment directly to said doctor such sums as may be due on owing him for chiropractic service rendered me. I understand I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me. This agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment.

I have read and agree to be bound by the terms of his assignment of benefits. I have also been advised that if my insurance company does not cooperate in protecting said doctor's interest, he will not await payment but may declare this entire balance due and payable; these assigned proceeds shall not exceed amounts due and payable to said doctor for services rendered.

Parent/Guardian Signature: _____ **Date:** _____

I have had a copy of ChiroCarolina's "HIPAA Notice of Privacy Practices" made available to me. I am welcome to take a copy with me and may return to get a copy at any time.

Parent/Guardian Signature: _____ **Date:** _____

CHIROCAROLINA

Dr. Henry E. Rice / Dr. Ferzaan A. Ali / Dr. R. Scott Saario
537 West Sugar Creek Road, Suite 101, Charlotte, North Carolina 28213

Name: _____ Date: _____

Does your child have health insurance?

_____ Yes, please read, make a selection and sign at the bottom.

_____ No, please sign here. _____ and continue to the next page.

For the patients with health insurance…
The staff of ChiroCarolina has advised that the cost of my treatment for the injuries sustained in an automobile accident that occurred on _____/_____/_____ may be covered in whole or part by both my own health insurance and by the liability insurance of the party at fault.

The staff has informed me that if I file my own health insurance, I will be responsible for paying deductibles and co-payments and that any such payments will be due as treatment is received. The staff has provided me with the factual information regarding the various forms of reimbursement available to me and has answered my questions.

I have decided that I do not wish to file any claims on my own health insurance. I hereby direct and authorize the clinic to send bills and treatment records only to my attorney, or to the liability insurance carrier, or to my own automobile insurer for the purpose of receiving payment under my Medical Payments, Uninsured or Under-Insured Motorist coverage, if applicable.

I understand that the clinic will rely on my decision and render treatment based on the assumption that payment will be received from sources other that my health insurance. I will not be expected to pay deductibles and co-payments, and third party payors will be billed at the clinic's usual rates rather than at discounted rates that may apply to in-network providers.

I understand that contractual and statutory deadlines may prevent me from filing on my own health insurance at a later date and that I should consider the decision I am making today not to file on my health insurance to be irreversible.

I understand that if for any reason, my liability claim is ultimately denied, compromised or litigated unsuccessfully, I will remain personally liable for the reasonable value of the treatment rendered to me by the clinic.

I, _____, do not want my child's health insurance filed.
(print name)

Parent/Guardian's Signature: _____ Date: _____

OR, After reading and carefully considering the above information, I, _____
(print name)

choose to have my child's health insurance filed and **will pay any and all co-pays and/or deductibles at each visit** as required by contract with my health insurance company.

Parent/Guardian's Signature: _____ Date: _____

CONSENT TO TREAT A MINOR

Name of Minor: _____ Date of Birth: _____

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced minor ("the minor"), and hereby authorize ChiroCarolina to administer as it so deems necessary to the minor. In the event that the minor has received treatment at your practice previous to the date of this consent form, I hereby authorize such treatment in addition to the treatment mentioned above. I further authorize the minor to complete and sign any documents at ChiroCarolina which are customarily completed and signed by patients at your practice as a condition to treatment, and such signatures shall serve as my own. In no event shall my signature to any other such document have any effect on this consent form.

Full Name of Parent/Legal Guardian (please print clearly): _____

Relationship to Minor: (circle one) Parent / Adoptive parent with custody / Legal Guardian / Other (specify): _____

SSN of Parent/Guardian: _____ D.O.B. of Parent/Guardian: _____

Address of Parent or Guardian: _____ Phone: (_____)_____-_____

Signature of Parent or Guardian: _____ Date: _____

CHIROCAROLINA
537 West Sugar Creek Road, Suite 101
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Dr. Henry E. Rice
Dr. Ferzaan A. Ali
Dr. R. Scott Saario

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of ChiroCarolina to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to ChiroCarolina any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on _____ (date of accident) to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to ChiroCarolina, from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due or may be due to ChiroCarolina for its services rendered.

I appoint ChiroCarolina as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am named a payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with ChiroCarolina.

I authorize ChiroCarolina to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to ChiroCarolina for services rendered including any balance remaining after the application of insurance payments and settlement of judgment proceeds. If ChiroCarolina is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse ChiroCarolina for its cost of recovery including reasonable attorney's fees.

_____	_____	_____
Print Patient's Name	**Signature** of Patient's Parent or Guardian	**Date**

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, ChiroCarolina hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injuries in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

ChiroCarolina hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. ChiroCarolina agrees to be bound by any confidentiality agreement regarding the contents of the accounting.

CHIROCAROLINA

By: _____

Automobile Accident Questionnaire

Date: _____/_____/_____ Date of Accident: _____/_____/_____ Chart #: _____

Patient's Name: _____

Driver of vehicle child was in: _____

Insurance Company: _____ Phone: (_____) _____-_____

Policy Number: _____ Claim Number: _____

Name of person who has made contact with you: _____

Driver of other vehicle: _____

Insurance Company: _____ Phone: (_____) _____-_____

Policy Number: _____ Claim Number: _____

Name of person who has made contact with you: _____

Have you retained an attorney for your child: ☐ Yes ☐ No ☐ Not Yet

If so, his/her name & phone #: _____

Please explain how your child's accident happened: _____

_____

_____

Street/Intersection where accident occurred: _____

Number of people in your child's vehicle: _____ Were the police notified? ☐ Yes ☐ No

Where was your child seated in the vehicle? ☐ Driver's Seat ☐ Front Middle ☐ Front Right
☐ Back Left ☐ Back Middle ☐ Back Right

Was your child wearing their seatbelt? ☐ Yes ☐ No

Was your child in a infant/toddler/child car seat or booster seat? ☐ Yes ☐ No

Did the vehicle's airbags inflate? ☐ Yes ☐ No

Did your child feel pain immediately after the accident? ☐ Yes ☐ No Where? _____

Did your child's head strike the windshield or other object? ☐ Yes ☐ No What? _____

Was your child knocked unconscious? ☐ Yes ☐ No If so for how long? _____

Did your child go to the hospital/urgent care/ doctor after the accident? ☐ Yes ☐ No

If so, where(name of facility)? _____ Were x-rays taken? ☐ Yes ☐ No

List any medications or treatments prescribed or taken for this injury: _____

_____

Has your child ever had any injuries in the involved area before? ☐ Yes ☐ No

Has your child ever been involved in a motor vehicle accident in the past? ☐ Yes ☐ No

Are your child's activities restricted as a result of this accident? ☐ Yes ☐ No

Since the accident, are your child's symptoms ☐ Improving ☐ Getting Worse ☐ The Same