

Motor Vehicle Accident Assessment Form

Your name: _____

Today's date: _____

Location of accident: _____

Date of accident: _____

Where were you sitting?

- Driver seat Front Right
 Rear Left Rear Right

Where was your car hit?

- Rear-end Front-end
 T-Bone Other _____

On which side was your car hit?

- Left-side Right-side
 Other _____

Did you lose consciousness? Yes No

Did the airbag deploy? Yes No

Have any X-rays/CT scans/MRIs been taken? Yes No

Were you wearing a seatbelt? Yes No

Was there a police report filed and who was at fault? _____

What symptoms did you have after the accident/injury? _____

What was your treatment **on the day** of the accident/injury? _____

What has been your treatment **since** the accident/injury? _____

Which doctors have you seen regarding this accident/injury? _____

What symptoms you are experiencing now? (Start with the worst complaint) _____

Have your symptoms gotten better or worse since the accident/injury? _____

Did any of your present symptoms exist before the accident? Yes No (please describe) _____

If Yes, how or are the symptoms different? _____

Do you think that these symptoms are directly related to the accident/injury? _____

Have you received other treatments for these same areas in the past? Yes No

If so, what were the treatments? _____

Automobile Insurance/Attorney Information

Please provide us with information about automobile insurance coverage (yours and the party that injured you) and attorney. Please provide the staff with a copy of your automobile insurance card if you are using this insurance.

Have you hired an attorney for this case? Yes No

If yes, please provide attorney name _____ attorney phone _____

My case is: currently in litigation closed and no longer in litigation Other _____

I have a copy of the police report concerning this accident: Yes No

Med Pay Information (your auto insurance coverage)

Insured: _____

Insurance Co: _____

Mailing address: _____

Agent: _____

Agent tel. #: _____

Policy #: _____

Med pay \$ amount: _____

Claim # _____

Liability Information (at fault party's coverage)

Name of party at fault: _____

Policy holder: _____

Insurance Co: _____

Mailing address: _____

Policy #: _____

Adjuster's name: _____

Adjuster Tel. #: _____

Have you filed a claim? Yes No

Claim #: _____

| | | |
|------------------------------------|--|---------------------|
| Form reviewed by: | Received and logged by billing department: | |
| _____ | _____ | _____ |
| Signature of practitioner and date | Date | Signature of biller |

Physician's Contract, Notice of Assignment and Authorization Form, Consensual Lien

Patient: _____

Today's date: _____

Patient's date of birth: _____

Date of injury: _____

Patient's attorney: _____

Attorney's telephone #: _____

I hereby authorize the staff of AZ Dentist (the "Physician") to furnish my attorney, liability insurance company, or health insurance carrier, a full report of all medical records and charges concerning my evaluation and treatment regarding my accident or potential legal action. I agree to complete any additional necessary authorizations to release protected health information as required by state or federal laws, including without limitation, the Health Insurance Portability and Accountability Act of 1996.

I authorize and direct my attorney and any indemnifying insurance companies, to pay directly to the Physician such sums due and owed to the Physician for services as a result of the above-subject incident and by reason of any other charges such as medical reports, conferences, depositions, and court appearances, that are due to Physician, and to withhold such sums from any settlement, judgment, or verdict as may be necessary to compensate and adequately protect the Physician. Furthermore, I hereby assign to the Physician any and all proceeds of any settlement, judgment, or verdict which may be paid to my attorney or myself as a result of the injuries for which I have been treated or injuries in connection therewith to the extent of my indebtedness to the Physician.

I agree that regardless of the outcome of this legal case, I am fully and directly responsible to the Physician for the payment of all charges submitted by the Physician for professional and other requisite administrative services rendered for my benefit. This contract is made for the Physician's protection and in consideration of the Physician awaiting payment for professional services rendered, which the Physician would otherwise so agree. Also, I understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I also agree to waive the defense of the statute of limitations in the event it is necessary for a legal claim to be filed against me for this unpaid bill if the bill remains outstanding beyond the statute.

In the event that any party to this contract and assignment commences legal proceedings against the other to enforce the terms hereof, or to declare rights hereunder as the result of any breach of any covenant or condition of this contract and assignment, the prevailing party in any such proceeding

shall be entitled to recover from the losing party its cost of suit, including reasonable attorney's fees, as may be fixed by the court. I hereby agree and instruct that in the event another attorney is substituted in this matter, the new attorney will be subject to the terms and conditions of this contract and assignment as inherent to the settlement and enforceable upon the case as if it were executed by the new attorney. For avoidance of doubt, the Physician is a party to this contract by virtue of performing professional services per the terms of this contract.

I fully understand that if my care by the Physician is subject to reimbursement by my health insurance carrier(s), I expressly agree that the Physician may bill and collect the full contractual amount of the billed charges for medical services provided and is not limited by the amount of fees as may be paid by those carriers. I specifically acknowledge and agree that the Physician may bill and collect the full billed charges from any and all sources of payments involved in this case, including, without limitation, defendants, health insurance companies, med pay coverage, and legal settlements, as applicable. Finally, I agree that I am personally and fully responsible for payment of any remaining balance.

Through my signature below, I agree that the Physician, in consideration for health services rendered, has a lien against all settlements, judgements, and insurance benefits which may become available, as allowed per Arizona law.

I have been advised that if my attorney does not wish to cooperate in protecting the Physician's interest as outlined in this contract, then the Physician will not await payment but will require me to make payments on a current basis.

Through my signature below, I am electing not to use any coverage potentially available under a health insurance or similar medical benefit plan that covers my injuries as an insured or dependent.

Through my signature below, I further allow the Physician to file a lien pursuant to ARS 33-931 against any liability insurance coverage stemming from my injury which occurred on or about the date of injury listed above.

Upon the Physician's request, either myself or my attorney shall provide the Physician with a proposed distribution of the settlement monies that contains a complete list of how the monies would be distributed.

Date: _____

Patient Signature: _____

Attorney's Agreement and Acceptance

The undersigned, being the attorney of record for the above patient, does hereby agree to observe and comply with all the terms of this document and agrees to withhold such sums for any settlement, judgment, or verdict as may be necessary to compensate and adequately protect said Physician named above. The attorney also agrees to advise the Physician within 10 days of notice of any change of the conditions of this case that may jeopardize payment of the amounts owed to the Physician. the attorney agrees the Physician will have no liability for attorneys' fees and costs, and that there will be no reduction in the amount paid to the Physician according to the common fund doctrine (LaBombard v. Samaritan Health System, 195 Ariz. 543).

Date: _____ Attorney Signature: _____

Personal Injury Assessment Form

Your name: _____

Today's date: _____

Date of accident/injury: _____

Where did the accident/injury occur? _____

What were the circumstances regarding the accident/injury? _____

What was your treatment on the day of the accident/injury? _____

What has been your treatment since the accident/injury? _____

What are the symptoms related to your injury that you are experiencing now? _____

Have any X-Rays/CT scans/MRIs been taken? If so, please list dates and facilities: _____

What other doctors/clinics/hospitals/facilities have you seen for treatment related to the injury? Please list dates and specific names of the treating facilities: _____

Do you have an attorney? No Yes (please provide name and telephone number) _____

My case is currently in litigation closed and no longer in litigation Other _____

Form reviewed by _____

Signature of practitioner

date