OPTIMAL HEALTH
CHIROPRACTIC CENTER

MOTOR VEHICLE ACCIDENTS

We are happy to attempt to work with your auto-insurance provider should you suffer injuries related to a motor vehicle accident. Please be advised that reporting your injury to your auto insurance provider should be your first step when attempting to file a claim for a MVA. Due to certain restrictions and regulations your claim for care may be denied if you do not properly notify your auto insurance provider or if you do not have med-pay coverage.

In order for us to begin a MVA Case, we require the following additional information **BEFORE** YOU CAN BE SEEN BY A PHYSICIAN AT OPTIMAL HEALTH CHIROPRACTIC CENTER:

1. **MVA Injury Supplement Forms – These forms ask questions in relationship to your injuries specific to your MVA claim**.
2. **Copy of your Auto Insurance Card**
3. **Claim Number**
4. **Adjuster's Contact Name and Phone**
5. **Claims Mailing Address**
6. **Your PHOTO ID for verification purposes.**
7. **Copy of YOUR personal health insurance card (should care not be covered or med-pay funds unavailable)**

If we do not have all of the above information by the time of your examination your claims may be denied by your Auto Insurance payor.

For more information or questions about insurance, please contact our insurance specialist, Eunice Zalesov at Eunice.ohcc@gmail.com.

REQUEST FOR ASSIGNMENT OF MEDICAL BENEFITS TO HEALTH CARE PROVIDER

Name of Patient: _____

Name of Insured (if different from patient): _____

Insurance Company: _____

Health Care Provider: _____

I am entitled to medical benefits under a policy of insurance written by the above insurance company. I have received treatment for an injury from the above health care provider.

As allowed by T.C.A. §56-7-120, I hereby assign to the above health care provider, from the medical benefits to which I am entitled, a sum of money sufficient to cover the charges of that health care provider for the services I have received. I hereby request that the above insurance company pay that money directly to the health care provider.

I understand that the amount which is paid to the above health care provider may be limited by the amounts owed to other health care providers who have provided services to me for the same injury and by the amount of medical benefits to which I am entitled under the policy.

If the above insurance company does not permit the assignment of benefits, I hereby request that the company disburse the medical benefit sums to which I am entitled in the form of a check issued in the names of the insured and the above health care provider as joint payees and sent to the office of the provider.

I understand that if the medical benefits available to me under the policy are insufficient to cover the charges of the above health care provider, I am responsible for paying that portion of the provider's charges not covered by insurance.

_____
Patient

Date:_____

_____
Witness

OPTIMAL HEALTH
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Confidential Patient Information

Dr Daniel Holland D.C.
2530 North Mount Juliet RD | Mt. Juliet, TN 37122
phone: (615)7586422 | fax: (615)758-6426

AUTO ACCIDENT: ADDITIONAL INFORMATION FORM

Is Today's visit due to an automobile injury: □ Yes □ No Date Of Injury: __ __ / __ __ / __ __ __ __

RESPONSIBLE PARTY INFORMATION:

Responsible Party's Name: _____

Address: _____

_____

Responsible Party's Insurance Company: _____

Adjustor:_____ Phone Number: (__ __ __) __ __ __ - __ __ __ __ X _____

Claim Number:_____

ATTORNEY INFORMATION:

I have retained an attorney: □ Yes □ No

Attorney's Name: _____ Phone Number: (__ __ __) __ __ __ - __ __ __ __ X _____

Address: _____

_____

ACCIDENT INFORMATION:

Date of Accident: __ __ / __ __ / __ __ __ __ Time of Day: __ __ : __ __ AM / PM Were there witnesses?: □Yes □ No

Names of Witnesses: _____

Were you?: □ Driver □ Passenger □ Front Seat □ Back Seat

Number of People in your vehicle: _____

Were you wearing seatbelt?: □ Yes □ No

What directions were you headed: □ North □ South □ East □ West

On what street: _____

What direction was the other vehicle headed: □ North □ South □ East □ West

On what street: _____

Were you struck from: □ Front □ Behind □ Left □ Right

Approximate Speed of your car____ mph Other car's approx speed_____ mph

Were you knocked unconscious? □ Yes □ No If yes, for how long?_____

Were the police notified? □ Yes □ No

In your own words, please describe the accident:

_____

_____

_____

_____

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AUTO INJURY FORM CONTINUED

Did you have any physical complaints BEFORE THE ACCIDENT? □ Yes □ No
If yes, please describe:

_____

_____

Please describe how you felt:

A. DURING the accident: _____

B. IMMEDIATELY AFTER the accident:_____

C. LATER THAT DAY:_____

D. THE NEXT DAY: _____

Do you have any congenital (from birth) factors which relate to this problem? □ Yes □ No
If yes, please describe: _____

Do you have any previous illness which relate to this case? □ Yes □ No
If yes, please describe: _____

Have you ever been involved in an accident before? □ Yes □ No
If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received:

_____

Where were you taken after the accident? _____

Have you had X-rays/MRIs since the accident? □ Yes □ No Specify_____

Have you been treated by another doctor since the accident? □ Yes □ No

Doctor's Name(s):_____

Have you lost time from work due to of this accident? □ Yes □ No

If yes, please complete following:

Last Day Worked:____/____/_____ Type of Employment:_____ Present Salary:_____

Are you being compensated for lost work: □ Yes □ No

Do you notice any activity restrictions as a result of this injury? □ Yes □ No

If yes, please describe: _____

Other pertinent information:

_____

_____

_____

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PERSONAL INJURY PAYMENT POLICY

Optimal Health Chiropractic Center will occasionally accept patients who have been injured in a motor vehicle accident or other liability injury; however the decision is up to the provider whether or not to see an injured patient. There is no guarantee for payment even if the injury is covered under a first-party payer. Optimal Health Chiropractic Center has the right to be reimbursed for any medical benefits from the proceeds of any personal injury policy (PIP), Medpay, uninsured or underinsured motorist coverage, or workers compensation coverage's applicable to this incident.

The patient is ultimately responsible for all balances owed on their account. Optimal Health Chiropractic Center may agree to accept a payment plan according to OHCC's policy if the patient is unable to pay the balance in full.

Your insurance company may choose to submit payment for your medical costs directly to you to disperse accordingly – do not assume they will directly pay this claim for you. Payment should be made within 30 days payable to 'Optimal Health Chiropractic Center'. If you are unable to pay in full please contact Eunice Zalesov by email:*eunice.ohcc@gmail.com* to make necessary arrangements as we do understand that sometimes insurance companies may take longer to process claims, especially for complex injuries.

While we do not wish to do so, failure to pay or agree to a payment plan within 60 days of the above statement will result in your account being placed with a collections company.

ADDITIONAL INFORMATION FOR 3RD PARTY INSURANCE BILLING

In most cases, third party insurance companies will not consider your claim until you have completed and been dismissed from care. This means it is *very* important to attend all appointments as recommended by your physician; cancelled and missed appointments may affect your ability to qualify for insurance reimbursement.

It is the responsibility of the patient to inform their assigned insurance adjuster that they are seeking medical care for injuries sustained. It is also the responsibility of the patient to inform their assigned adjuster when they have completed care and to send a request for your records.

It is our policy for third party insurance to hold all statements and billing until you have been dismissed from care or reached maximum clinical improvement. Upon dismissal by our physician or abandonment of your recommended treatment we will submit your final bill directly to you. At this time we recommend contacting your insurance adjuster to notify you have completed care and are ready to settle your claim.

_____ _____

Signature Date