Gonstead Chiropractic Clinic, P.C.

AUTO ACCIDENT INFORMATION

Patient's Name: _____ Today's Date: _____/_____/_____

DOB_____ Claim Number: _____

AUTO RELATED ACCIDENT

Date & Time of Accident_____ ☐ am ☐ pm

Were you the: _____ Driver _____ Front Passenger _____ Rear Passenger

Were you wearing a seatbelt? ____yes ____no Did airbags inflate? ___yes ___no

Did your head strike the headrest, windshield, or window? ___yes ___no

Did any part of your body strike any part of the vehicle? ___yes ___no

Please explain_____

_____

What was the position of your body and head at impact? _____

Did you anticipate the impact? _____

How did you feel the day of the accident? _____

Which area of the vehicle was impacted? _____

What was the approximate speed of the vehicles involved? _____

What were the road conditions? _____Weather conditions: _____

Damage to your vehicle: _____

Other driver's vehicle: _____

AFTER INJURY

Did the accident render you unconscious? ___yes ___no

Please explain _____

Have you received any other care for this injury? ___yes ___no

When & Where _____

Were x-rays taken? ___yes ___no If so, what parts of body? _____

Meds prescribed? ___yes ___no Please list: _____

Please explain symptoms you are experiencing as a result of this accident: _____

_____

Are you able to work? ___yes ___no Have you retained an attorney? ___yes ___no

1301 Shiloh Road, Suite 1310 ■ Kennesaw, GA 30144 ■ (770) 420-8818 ■ (770) 420-0083 fax

GONSTEAD
CHIROPRACTIC CLINIC

MEDICAL PROVIDER'S CONTRACT

This is an agreement between the undersigned _____, hereafter called "patient", and **GONSTEAD CHIROPRACTIC CLINIC, P.C.**, hereafter called "provider", for full and complete payment of the provider's medical services and expenses by the patient from the proceeds for any insurance settlement, judgment at trial, or recovery from any other means or sources.

In consideration the provider hereby agrees to provide, following the reasonable request and appropriate authorization, reports of care to the patient's attorney without charge to the patient's attorney.

In further consideration the provider agrees upon reasonable request and appropriate authorization to meet with patient's attorney to discuss the treatment of the patient. Such meeting shall be of reasonable duration in consideration of patient's condition and shall be without charge to patient or attorney.

Patient agrees to pay provider regardless of the outcome of any case, claim or litigation in which the provider's reports, notes care and treatment plan are used.

Following the outcome of the claim, case or litigation, if collection becomes necessary, patient will then become liable for interest at the highest current legal rate and provider's attorney fees and expenses for successful collection of fees for services.

A copy of this contract is to be sent to the patient's attorney with a request the attorney follow these directions in making payment from any recovery to the undersigned provider.

This agreement shall follow the patient and binds all attorneys or firms handling the patient's case.

Patient directs his attorney to withhold payment of the provider's total bill for services/ expenses for any settlement to recovery from whatever source and to make payment immediately to the provider.

This is an obligation coupled with an interest. It is NOT an agreement for payment based upon the outcome of any claim or litigation.

If any clause or provision of this agreement becomes illegal, invalid, or unenforceable for any reason it is the intent of the parties that the remaining part of this agreement not thereby be affected.
This agreement does not waive any right of the provider or preclude the provider from any reasonable actions to collect.

Read, understood, agreed and signed by these parties on this date ____/____/____.

_____ _____
Provider Patient

_____
Attorney

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