Railing Chiropractic & Acupuncture

Vehicle Accident Information

Patient Information

Patient Name:_____ Date of Accident:_____

Time of accident:_____ AM/PM

Please describe the accident in your own words:_____

_____

_____

Claim #:_____ Insurance Company:_____

Your Vehicle

Make and model:_____

Were you wearing a seatbelt? Yes No

Did your vehicle have airbags? Yes No

If so did they deploy? Yes No

Impact

Did any part of your body strike the vehicle?

_____

The impact was from the: (Please circle)

Rear Front Right Left Other:_____

Other Vehicle

Make and model:_____

Estimated speed at time of impact?_____

At the time of impact were you: (Circle)

Looking straight ahead Looking right

Looking left Looking down

Looking up

Police

Did the police come to the scene? Yes No

Where there witnesses? Yes No

Was a police report filed? Yes No

Was a violation issued? Yes No

If yes, to whom_____

Patient Condition

Were you transported from the scene? Yes No

If so, where? _____

How were you transported?

Ambulance Private vehicle

Were X-rays taken at the hospital? Yes No

Symptoms / Injuries

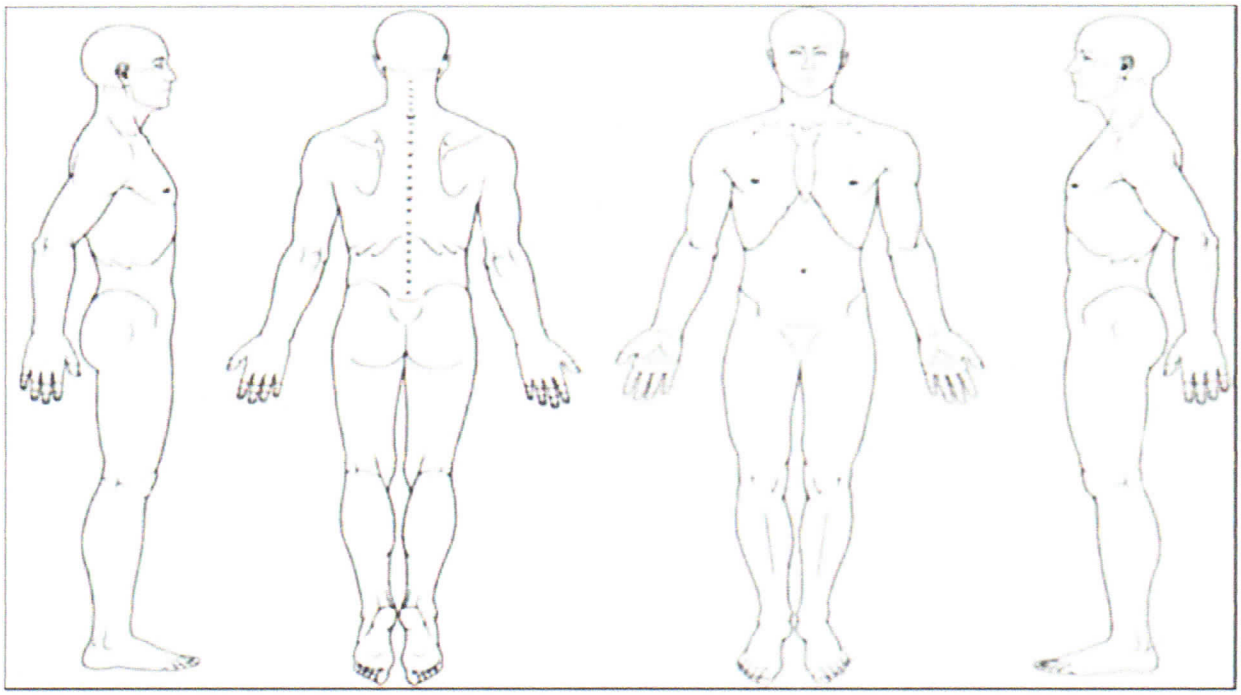
Have you experienced any of the following symptoms following the accident? (Please circle)

Arm/Shoulder pain	Feet/toe numbness	Neck pain	Back Stiffness
Headaches	Shortness of breath	Chest pain	Irritability
Sleeping difficulty	Dizziness	Jaw pain	tension
Upset stomach	Buzzing in ears	leg pain	Memory loss
Blurred vision	Fatigue	Nausea/vomiting	Back pain

What type of pain have you been experiencing since the accident? (Please circle)

Sharp	Dull	Throbbing	Numbness
Achy	Shooting	Burning	Tingling
Cramping	Stiffness	Swelling	Tearing

Other:_____



Please mark areas of pain/Numbness/Discomfort

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, have a change in our health.

_____ _____

Signature of Parent, Guardian, or Personal Representative Date

_____ _____

Print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

OFFICE OF INSURANCE REGULATION

Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

CHIROPRACTIC AND THERAPIES

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)* Signature Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been

C. provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

DR. CHRISTOPHER A RAILING

Name *(PRINT or TYPE)* Signature Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.
Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may
not be electronically furnished. Failure to furnish this form may result in non-payment of the claim.