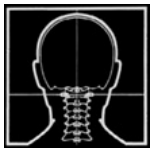

Atlas Family Chiropractic
Dr. Maggie A Sellers, DC

1255 Boyson Loop Hiawatha, IA 52233 Telephone: (319) 393-7744 Fax: (319) 393-1035

PATIENT INFORMATION

Name (First, Middle Initial, Last)_____

ACCIDENT INFORMATION

Was this injury caused by □Auto Accident □Work Related Date of Accident_____
Describe how the accident happened and any immediate medical attention received after this accident

_____

_____

_____

RESPONSIBLE PARTY

If you indicated an automobile Accident, please complete the following:
Name & Address of at Fault Individual:

_____

_____ Phone #_____
Name of Automobile Insurance Company_____
Insurance Agent Name_____ Phone #_____
Claim#_____

YOUR AUTOMOBILE INSURANCE

Name of Automobile Insurance Company_____
Insurance Agent Name_____ Phone #_____
Claim#_____
Has a claim been filed with your auto carrier for this accident? □No □Yes Date Filed:_____

WORKER'S COMPENSATION INFORMATION

If you indicated a Work Related Accident, please complete the following:
Name & Address of Employer _____

_____
Contact Person_____ Phone #_____
Has a claim been filed with your employer for this accident? □No □Yes Date Filed:_____

ASSIGNMENT OF BENEFITS

I hereby give permission for any and all insurance companies to pay Atlas Family Chiropractic directly for services provided as a result of this accident.

Patient/Legal Guardian Signature Date

MEDICAL INFORMATION RELEASE

I authorize the release of any medical information necessary to process claims for Atlas Family Chiropractic.

Patient/Legal Guardian Signature Date

Motor Vehicle Accident Claims

Upon completion of the Accident Information form, the insurance company of the claimant will be called to verify their intent to pay. If they will pay directly to this office upon receipt of claim, all claims will be filed directly to them.

Should the responsible insurance company refuse to pay upon receipt of claims, the patient's automobile insurance company will be contacted and claims will be submitted to them for payment.

If no payment is issued within 90 days from the start date of treatment, the outstanding balance will become your responsibility. You may also opt to pay your charges as they are incurred. In either case, any overpayment will be reimbursed back to you.

If you become responsible for the outstanding balance and it becomes past due, we will proceed with collections.

Worker's Compensation Claims

Claims will be submitted on your behalf to your employer, or any company reported to us by your employer.

If no payment is issued within 90 days from the start date of treatment, the outstanding balance will become your responsibility. You may also opt to pay your charges as they are incurred. In either case, any overpayment will be reimbursed back to you.

If you become responsible for the outstanding balance and it becomes past due, we will proceed with collections.

I have read and understand the written payment policy stated above. I understand that responsibility for payment on this account is ultimately mine.

Patient/Legal Guardian Signature Date