DIXON CENTER FOR INTEGRATIVE HEALTH CARE
Andrew Dixon, DC • Christy Diaz, DC • Jason Payne, DC

HARPETH VALLEY HEALTH CENTER
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Wellness Practitioner Kelli Thomas

PERSONAL INJURY OFFICE POLICIES

The following information outlines Dixon Center and Harpeth Valley Health's policies on personal injury cases. This is also a guide for our patients to help ease the process of handling these claims and provide you with the best financial guidance.

Please read through this carefully and ask us any questions.

1. It is the policy of Dixon Center to bill all personal injury claims to the patient's Med-pay first.
Med-pay is medical insurance provided through your personal automobile insurance policy. You are eligible to use his benefit for injuries related to a motor vehicle accident, regardless of who is at fault. Med-pay will pay for your medical expenses as you receive treatment up to your yearly allotted maximum (ex: $5,000). The payments also typically come directly to the provider. By using Med-pay insurance, you are able to treat as needed without worry of whether it will be covered. If another person is at fault for the accident, your Med-pay will subrogate with the 3rd party insurance to be reimbursed. Legally, your rates cannot increase if you use this benefit.

2. If Med-pay is unavailable, you may choose to be represented by an Attorney.
Our office can provide you with a list of several attorneys who are experienced in dealing with automobile injury cases. The attorney will deal directly with both the automobile insurance companies and aid in reaching a settlement for your medical expenses. We will bill your attorney directly upon request for your records, and payment will be made directly to the doctor providing your care for expenses you have incurred in our office. Per our office policy, we require you and the attorney to sign an "Attorney Lien," which requests that your attorney will pay the doctor directly upon settlement. If this form is not signed, the balance will remain your responsibility until you and your attorney do sign the form. Also, if a settlement is not reached before three months, it will become the patient's responsibility to start making monthly payments towards the balance until the final settlement is received.

3. If Med-pay is unavailable, a Third Party insurance carrier may be billed if liability is accepted.
Claims billed to the Third Party are not paid until after the end of your treatment. Therefore, a balance will incur on your account for services rendered. Because no contract discount is applicable, you will notice our standard fees for services will be applied to your balance. Since these insurance companies do not represent you, they may offer you a lump settlement before you are finished with treatment. We recommend that you never accept these offers until you know you are fully recovered. Third Party cases cannot be re-opened once you settle.

Our office policy requires that you sign a "Request for Assignment of Medical Benefits to the Health Care Provider" form, which requests the third party to pay the doctor directly upon settlement. If this form is not signed, the balance will remain your responsibility in full until it is signed. Also, after you have been released of care, we require that the balance must be paid within 30 business days. If no payment is received within this time frame, it will become your responsibility to start making monthly payments towards the balance until the final settlement is received. Also, if the third party does send the settlement check directly to you, it must be sent to our office within 5 days receipt to clear your account.

4. Dixon Center does not bill major medical insurance plans for personal injury cases, except for out of state personal injury claims or if the patient is at fault and does not have Med-pay.
It is the policy of our office not to involve major medical insurance plans where another party is at fault for payment of medical expenses. The only time our office will bill a major medical plan is if the accident occurred out of state or if you do not have Med-pay and no other party is responsible for medical payments.

5. The purchase of any product or medical device is the patient responsibility.
Products for sale within the office are not billable to personal injury cases. These must be paid for at the time of service.

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PERSONAL INFORMATION

Name:_____ **Email:**_____

Primary Phone: _____ **Secondary Phone:** _____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

DOB:_____ **Age:** _____ **Sex:** ☐ Male ☐ Female **SS#:**_____

Employer's Name:_____

Employer's Address:_____ **City:**_____ **State:**_____ **Zip:**_____

MEDPAY INFORMATION (if applicable)

Insurance:_____ **Policy #:**_____

Agent Name: _____ **Agent Phone:** _____ **Claim #:** _____

Insurance Co. Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Name on Policy (if other than self):_____

THIRD PARTY INFORMATION (if applicable)

Responsible Party's Name:_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Responsible Party's Insurance Co:_____ **Policy #:**_____

Agent Name: _____ **Agent Phone:** _____ **Claim #:** _____

Name on Responsible Party's Policy:_____

ATTORNEY INFORMATION (if applicable)

Name:_____ **Phone:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

NATURE OF ACCIDENT

Date of Accident: _____ **Time of Day:** _____ **AM/PM**

I was the: ☐Driver ☐Passenger **Sitting In:** ☐Front Seat ☐Back Seat **#People in vehicle:** _____

All Wearing Seat Belts? ☐Yes ☐No **Size Of Your Vehicle:** ☐Mini ☐Compact ☐Midsize ☐SUV ☐Truck

Size Of Vehicle That Impacted Your Vehicle: ☐Mini ☐Compact ☐Midsize ☐SUV ☐Truck

Printed Name: _____ **DOB:** _____/_____/_____

NATURE OF ACCIDENT (continued)

I was headed: ☐North ☐South ☐East ☐West **On (street):** _____

They were going: ☐North ☐South ☐East ☐West **On (street):** _____

I was struck from: ☐Behind ☐Front ☐My Left ☐My Right **My Speed:**_____MPH **Their Speed**_____MPH

Road Conditions: ☐Dry ☐Slick ☐Wet ☐Icy ☐Snow ☐Other _____

I was knocked unconscious: ☐Yes ☐No **Airbags Deployed:** ☐Yes ☐No **Police Notified:** ☐Yes ☐No

Any known witnesses: ☐Yes ☐No **Names:**_____

In your own words, please describe the accident: _____

_____

_____

Did you have any physical complaints BEFORE THE ACCIDENT? ☐Yes ☐No

If YES, please describe:_____

_____

COMPLAINTS + SYMPTOMS

Please describe your complaints and symptoms:

During the accident: _____

Immediately After:_____

First 24 hours: _____

Day Following: _____

Right Now: _____

What are your PRESENT complaints and symptoms? _____

_____

Do you have any congenital (from birth) **factors that relate to this problem?** ☐Yes ☐No ***If YES, describe:***

_____

Do you have any previous illness that may relate to this case? ☐Yes ☐No ***If YES, describe:***

_____

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COMPLAINTS + SYMPTOMS (continued)

Where were you taken after the accident? _____

Have you been treated by another doctor since the accident? ☐Yes ☐No ***If yes, please give doctors name and address:***_____

What type of treatment did you receive: _____

_____

Since this injury occurred, are your symptoms: ☐Improving ☐Getting Worse ☐Same

Check the symptoms you have noticed since the accident:

☐Back Pain	☐Ears Buzzing	☐Hands Cold	☐Loss of Smell	☐Pins/Needles: Arms
☐Chest Pain	☐Ears Ringing	☐Headache	☐Loss of Taste	☐Pins/Needles: Legs
☐Cold Sweats	☐Face Flushed	☐Heavy Head	☐Neck Pain	☐Sleeping Problems
☐Constipation	☐Fainting	☐Irritability	☐Neck Stiff	☐Shortness of Breath
☐Depression	☐Fatigue	☐Lights Too Bright	☐Nervousness	☐Stomach Problems
☐Diarrhea	☐Feet Cold	☐Loss of Balance	☐Numb Fingers	☐Tension
☐Dizziness	☐Fever	☐Loss of Memory	☐Numb Toes	☐Other*

**Other Description:* _____

Have you lost time from work as a result of this accident? ☐Yes ☐No ***If yes, please complete below:***

Last Day Worked:_____ **Employed:** ☐Full-Time ☐Part-Time **Present Salary**:_____

Are you being compensated for time lost from work? ☐Yes ☐No ***If yes, please state the type of compensation you are receiving:***_____

Did you notice any activity restrictions as a result of this injury? ☐Yes ☐No ***If yes, please describe in detail:*** _____

_____

Have you ever been involved in an accident before? ☐Yes ☐No ***If yes, please describe with date(s), type(s) of accident(s), and any injury(ies) received:***_____

_____

_____

Other Pertinent Information:_____

_____

AGREEMENT OF POLICY

I clearly understand and agree to the policies and procedures as determined by my personal injury case. I agree to pay all balances over 90 days from the original due date, as well as court costs and reasonable collection and attorneys' fees, with or without suit, incurred in collecting any past due balance. I certify that the information I am providing is correct to the best of my knowledge. I will not hold my doctor, provider or any other staff member responsible for errors or omissions that I may have made in the completion of this form. I hereby authorize Dixon Center for Integrative Health Care (and whoever may be designated as assistants) to administer such examination and treatment, as they deem necessary.

_____ _____ _____

Printed Name Signature Date

REQUEST FOR ASSIGNMENT OF MEDICAL BENEFITS TO HEALTH CARE PROVIDER

Patient Name:_____ Insurance Company:_____

Name of Insured:_____ Policy #:_____

(if other than patient)

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. I understand that the amount which is paid to the above health care provider may be limited by the amounts owed to the 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 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.

_____ _____ _____

Printed Name Signature Date

THIRD PARTY INSURANCE LIEN

I, _____ understand that due to circumstances, my insurance company does not and will not accept assignment on my insurance claims. I also fully understand that all insurance checks will be sent directly to me.

I hereby agree to forward all insurance checks and explanation of benefits received by me for services rendered in this clinic directly to Dixon Center/Harpeth Valley Health within 10 days of receipt of the check. I also know that if I fail to forward the insurance checks, I will then be personally liable for any and all the balances due on my account. This balance, I know, will be due in full upon request by Dixon Center/Harpeth Valley Health, should this situation occur.

_____ _____ _____

Printed Name Signature Date

DOCTOR – ATTORNEY LIEN

TO: ATTORNEY

_____

_____

_____

_____

FROM: PROVIDER

_____

211 & 213 Old Hickory Blvd.

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615-646-1003

Patient: _____

I do hereby authorize Dixon Center for Integrative Health Care to furnish you, my attorney, with a full report of his case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident, which occurred on _____.

I hereby give a lien to Dixon Center/Harpeth Valley on any settlement, claim, judgment, or verdict as a result of said accident, and authorize and direct you, my attorney, ***to pay directly to Dixon Center for Integrative Health Care*** with such sums as may be due and owing him for service rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect Dr. Dixon adequately.

I fully understand that I am directly and fully responsible to Dixon Center for Integrative Health Care for all chiropractic bills submitted by him for service rendered me, and that this agreement is made solely for Dixon Center's additional protection and in consideration of his awaiting payment, and I further understand that such a payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

PATIENT SIGNATURE: _____ **DATE:** _____

The undersigned, being attorney of record for the above patient, does hereby acknowledge receipt of the above lien and does agree to honor the same to protect adequately said above named doctor.

ATTORNEY SIGNATURE: _____ **DATE:** _____

NOTICE: Please date, sign and return one copy to Dixon Center/Harpeth Valley at once. Keep one copy for your records.