ACCIDENT REPORT

Name:____ Date:___________________

Your Insurance Company:____

Claim #:____ Policy #:____________________________

Insurance Company Phone #:___________________________ Agent:_____________________________

Insurance Company Address:____

____
City State Zip

Other Party's Insurance Company:____

Claim #:____ Policy #:____________________________

Insurance Company Phone #:___________________________ Agent:_____________________________

Insurance Company Address:____

____
City State Zip

Date of Accident:_______________________ Time of Accident:________________________ am / pm

Where did the accident occur? ____

How did the accident happen? ____

____

Were you unconscious? ☐ Yes ☐ No

Where were you taken after the accident? ____

Name of doctor? ____

What were you told was wrong with you? ____

What treatments did you receive? ____

Were any X-ray studies performed? ☐ Yes ☐ No

If so, what views were taken? ____

What medications were you given? ____

Are you still taking the medication? ☐ Yes ☐ No If so, what kind and how much? ______________

____

Are you still receiving treatment? ☐ Yes ☐ No If so, what kind and how often? ______________

____

Have you seen any other doctors? ☐ Yes ☐ No

If so, list names and when were they seen?____

Did you return to work? ☐ Yes ☐ No If no, how long were/are you off work? ____________________

What are your normal duties at work? ____

____

Are you unable to perform any of those duties? ☐ Yes ☐ No

Explain:____

____

What are your present complaints? ____

____

Have you had any previous accidents? ☐ Yes ☐ No

If so, state how you were injured:____

____

How long were you off work? ____

What treatments did you receive? ____

____

What problems, if any, have you had as a result of those injuries? ______________________

____

ASSIGNMENT AND RELEASE

In consideration of the agreement of Indigo Chiropractic LLC dba Indigo Chiropractic to delay billing me personally for medical treatment rendered until resolution of My Claim:

1. I now assign, without any right to later revoke, Indigo Chiropractic LLC dba Indigo Chiropractic all insurance benefits if any, otherwise payable to me for services rendered in this office.

2. If the insurance company does not acknowledge this assignment and I receive payment, I agree to reimburse Indigo Chiropractic in full within 14 days of receipt. **I realize that any use by me of these proceeds is taking or converting money that is the property of this clinic.**

3. I understand that I am financially responsible for all charges whether or not paid by insurance and that in case of default on my part, and it is necessary for this office or its agents to employ legal and/or collection counsel, I hereby agree that I am responsible for all collection charges incurred, which will be added to my bill.

4. I authorize Indigo Chiropractic to file my claim forms on my behalf.

5. Arizona law governs this Assignment. Jurisdiction shall be in Arizona, and venue shall lie in the county in which the Clinic is located, unless required by applicable law to lie in a different county in which I reside.

6. I authorize Indigo Chiropractic to release any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case, to secure payment of benefits.

7. **A photocopy of this Assignment shall be considered as effective and valid as the original.**

8. I have read this document and I fully understand it.

______________________	______________________	______________
(Print Patient Name)	(Signature of Patient)	(Date)

This Assignment has been signed on the Clinic Premises: ______________________ ______________

(Staff Witness) (Date)