Baker CHIROPRACTIC | WELLNESS

Enlightening, Adjusting and Saving Lives

Patient's Name: _____ Date of Injury: _____

Upon receiving proceeds on my behalf, I hereby authorize and direct my attorney to pay directly to Baker Chiropractic and Wellness such sums from any settlement, judgment, or verdict from my personal injury claim based on the accident referenced above, as may be necessary, to pay in full Baker Chiropractic and Wellness for reasonable and necessary services rendered on my behalf. I acknowledge that I alone, not my attorney, am responsible for my medical expenses. If settlement proceeds are not enough to pay my medical expenses, I understand I will still be directly and fully responsible to pay the balance due, regardless of the outcome of my personal injury claim.

This lien shall be irrevocable and shall be valid and enforceable out of the net proceeds of my settlement, judgment, or verdict. Net proceeds means the gross amount recovered, less any attorney fees and costs. This lien applies to sums currently owed, and to sums which may be incurred in the future, up to the time of settlement of my personal injury claim.

Date: _____ By:_____

Client name printed:

Client SS#:

In exchange for this lien the medical provider below will refrain from any collection efforts until my personal injury claim is resolved and will regularly provide copies of patient's current bills and balance to patient's attorney/law firm.

Date: _____ By:_____

Baker Chiropractic and Wellness

The undersigned, being attorney of record for the above patient, does hereby agree to withhold and pay such sums from the patient's portion of any settlement, judgment, or verdict as set forth above for the benefit of Baker Chiropractic and Wellness.

Date: _____ By:_____

Patient's Attorney

A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

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Automobile Collision Patient Information

NAME:_____ TODAY'S DATE:_____

ADDRESS:_____ CITY/STATE:_____ ZIP:_____

PHONE:_____ CELL:_____ EMAIL:_____

DATE OF BIRTH:_____ SEX: M/F AGE:_____

COLLISION DETAILS:

DATE OF LOSS:_____ LOCATION:_____ FAULT: PATIENT/OTHER DRIVER

DESCRIPTION OF CRASH: _____

_____

POLICE DEPT:_____ TICKET ISSUED: YES/NO TO WHOM: PATIENT/OTHER DRIVER

AMBULANCE: YES/NO EMERGENCY ROOM: YES/NO OTHER TREATMENT: YES/NO

LIST OF PROVIDERS:_____

_____

INSURANCE INFORMATION:

PATIENT AUTO INSURANCE (MEDPAY):_____

POLICY #:_____ CLAIM #:_____

ADJUSTER NAME:_____ PHONE:_____

ADDRESS:_____ FAX:_____

PATIENT HEALTH INSURANCE COMPANY:_____

MEMBER NAME:_____ MEMBER #:_____ GROUP #_____

ADDRESS:_____ PHONE:_____

AT-FAULT AUTO INSURANCE COMPANY:_____

POLICY #:_____ CLAIM #:_____

ADJUSTER NAME:_____ PHONE:_____

ADDRESS:_____ FAX:_____

ATTORNEY INFORMATION:

ATTORNEY NAME:_____ PHONE:_____

ADDRESS:_____

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Ohio Medical Payments Coverage: What Should I Know?
(often referred to as "MedPay" or "No Fault")

What is MedPay Coverage?

- Optional coverage you may choose to include in your auto insurance policy.
- Pays you or the passengers in your vehicle up to a specified amount for medical expenses related to an auto accident.
- Provides benefits no matter who is at fault in the accident.
- You pay extra for this coverage, essentially pre-paying for this benefit.
- By law, using your MedPay coverage does NOT affect your insurance premium.

When Do I Use MedPay?

- When you are involved in an auto accident, regardless of who is at fault, and you or a passenger in your vehicle incur medical expenses related to the accident.

How Do I Use MedPay?

- In order to utilize your MedPay coverage, you will need to open a claim with your auto insurance carrier. NOTE: Most, if not all, auto insurance policies require you to notify your insurance carrier any time you are involved in an accident, regardless of who is at fault, or you may risk losing insurance benefits.
- Upon opening a MedPay claim with your auto insurance carrier, you should direct all medical providers to bill your MedPay coverage first.

When Does My Health Insurance Pay?

- Once your MedPay coverage is exhausted, medical providers should then look to health insurance or other forms of payment for accident related expenses.
- Most health insurance plans (Medicare, Medicaid, and employer health plans) require you to use MedPay coverage first, before using your health insurance to pay for accident related medical expenses.
- You may need to submit proof (MedPay "exhaust" letter) to your health insurance carrier to show that you utilized all of your MedPay coverage first.

What Happens Next?

- If you were at fault in the accident, no further actions are necessary regarding MedPay.
- If the other driver's auto insurance carrier accepts responsibility for the accident, your auto insurance carrier may seek reimbursement from the other driver's carrier for some or all of the MedPay coverage it paid on your behalf.
    - If you don't recover a settlement for your injuries, you will have no obligation to repay what MedPay paid on your behalf.
    - If you do recover a settlement for your injuries, your settlement may be reduced or "off-set" by the amount of MedPay expenses paid on your behalf. The amount of any reduction or "off-set" is determined based on numerous factors.

***This MedPay overview is intended for general information purposes only and does not constitute legal advice. You should contact an experienced attorney to discuss your particular situation.*

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Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including but not limited to, Medicare, Medicaid, private insurance, medical payments coverage through my automobile insurance, and any other health/medical plan, to issue payment check(s) directly to Baker Chiropractic for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Baker Chiropractic to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination and treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Baker Chiropractic on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement.

A photocopy of this assignment is considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Witness Date