



MOTOR VEHICLE ACCIDENT ASSESSMENT FORM

Your name: _____

Today's date: _____

Location of accident: _____

Date of accident: _____

Where were you sitting?

Driver seat Front Right

Rear Left Rear Right

Where was your car hit?

Rear-end Front-end

T-Bone Other _____

On which side was your car hit?

Left-side Right-side

Other _____

Did you lose consciousness? Yes No

Did the airbag deploy? Yes No

Have any X-rays/CT scans/MRIs been taken? Yes No

Were you wearing a seatbelt? Yes No

Was there a police report filed and who was at fault? _____

What symptoms did you have after the accident/injury? _____

What was your treatment **on the day** of the accident/injury? _____

What has been your treatment **since** the accident/injury? _____

Which doctors have you seen regarding this accident/injury? _____

What symptoms you are experiencing now? (Start with the worst complaint) _____

Have your symptoms gotten better or worse since the accident/injury? _____

Did any of your present symptoms exist before the accident? Yes No (please describe) _____

If Yes, how or are the symptoms different? _____

Do you think that these symptoms are directly related to the accident/injury? _____

Have you received other treatments for these same areas in the past? Yes No

If so, what were the treatments? _____

Automobile Insurance/Attorney Information

Please provide us with information about automobile insurance coverage (yours and the party that injured you) and attorney. Please provide the staff with a copy of your automobile insurance card if you are using this insurance.

Have you hired an attorney for this case? Yes No

If yes, please provide attorney name _____ attorney phone _____

My case is: currently in litigation closed and no longer in litigation Other _____

I have a copy of the police report concerning this accident: Yes No

Med Pay/UM Information (your auto insurance coverage) Insured: _____
Insurance Co: _____
Mailing address: _____

Agent: _____
Agent tel. #: _____
Policy #: _____
Med pay \$ amount: _____
Claim # _____

Liability Information (at fault party's coverage)
Name of party at fault: _____
Policy holder: _____
Insurance Co: _____
Mailing address: _____

Policy #: _____
Adjuster's name: _____
Adjuster Tel. #: _____
Have you filed a claim? Yes No
Claim #: _____

Form reviewed by: _____ Signature of practitioner and date	Received and logged by billing department: _____ Date	_____ Signature of biller
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**MOTOR VEHICLE ACCIDENT/ PERSONAL INJURY
INSURANCE ELECTION FORM**

OPTION 1 – PERSONAL MEDICAL INSURANCE

I understand I could use my personal health insurance for my medical treatment. I understand I will be responsible for all co-pays and deductibles at the time of service that are associated with this insurance. I understand that all co-pays must be paid at the time of service based on the contractual agreement between my doctor and my health insurance carrier.

OPTION 2 – THIRD-PARTY LIABILITY INSURANCE AND/OR MY PERSONAL UM/MED-PAY INSURANCE

I understand I could instruct my doctor to bill the third-party liability insurance and any uninsured/underinsured or med pay insurance, applicable to my accident. I understand I will not be required to pay any copays or deductibles under this option. I am instructing my doctor to not bill my personal medical insurance and rather bill any applicable third-party liability insurance and/or UM/Med-Pay insurance.

I understand that this is a third-party liability claim (auto claim) and all expenses will be billed to the third-party insurance involved. I understand that Blick MVA Collections LLC dba ImpactMD Accident Care will hold my bills until I am released from their care. A Physician's Lien will then be filed and mailed via USPS Certified Mail to me. I also understand that payment is due when the case settles with the insurance carrier involved and that I am financially responsible for ALL charges, subject to state and federal laws regarding balance billing, whether or not paid by any insurance company and/or attorney.

In consideration of being treated without requiring payment until settlement of my insurance claim, I also hereby authorize Blick MVA Collections LLC dba ImpactMD Accident Care to endorse my name to any draft or check received by the above medical providers to be used for payment on my account.

I am instructing my doctor to proceed with:

OPTION 1 – USE MY PERSONAL MEDICAL INSURANCE

OPTION 2 – USE THIRD-PARTY LIABILITY INSURANCE AND/OR UM/MED-PAY INSURANCE

Print Name

Patient Signature

Date