THE CONCUSSION PLACE

Personal Injury Form

TODAY'S DATE:

PATIENT INFORMATION			
Last Name:	**First Name:**	**MI:**	**Birth Date:**

ATTORNEY CONCTACT INFORMATION

Attorney Name:

Office Address:	City:	State:	Zip:
Office Phone:	Cell Phone:	Fax:	
Attorney Email Address:			

CASE TYPE

☐ Automobile Accident ☐ Slip-and-Fall ☐ Assault ☐ Worker's Compensation ☐ Other:

CASE DETAILS

☐ Date of Incident Type of Injury: ☐ Concussion ☐ Whiplash ☐ Injury to limbs ☐ Other:

CONSENT TO RELEASE OF INFORMATION

I authorize full communication and full release of information between The Concussion Place and the attorney listed above as it pertains to this injury case.

Patient Printed Name	Patient Signature	Date Signed

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MEDICAL PROVIDER LIEN

Attorney Name: Date of Injury:

This is a contract between doctor and patient, to ensure that the doctor will be paid for services rendered associated with this incident. The reason for this document is to clearly state that I want Dr. Brad Gulla fully paid for the services rendered in this case. The attorney in this case is asked to sign this document as acknowledgment of the agreement between Dr. Gulla and his patient.

I do hereby authorize full communication and records release between Dr. Brad Gulla and my attorney with any and all information or documentation regarding this accident case. I hereby authorize and direct my attorney to fully, promptly, and directly pay Dr. Brad Gulla for any and all services rendered to me for injuries sustained in this accident, and to withhold such sums from any settlement, judgment or verdict as may be necessary to pay such obligations. I hereby further give a lien on my case to Dr. Brad Gulla against any and all proceeds of my settlement, judgment or verdict which may be paid to my attorney, or myself, as the result of the injuries for which I have been treated by Dr. Brad Gulla in connection with this accident.

I agree never to rescind this agreement and that a rescission by my attorney should not be honored. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to Dr. Brad Gulla for all medical bills submitted for service rendered me and that this agreement is made solely for Dr. Gulla's additional protection and consideration of awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to Dr. Gulla's office. I have been advised that if my attorney does not wish to cooperate with me in protecting Dr. Gulla's financial interest in this case, a lien may not be accepted for services rendered and other payment arrangements will be offered.

_____	_____	_____
Patient Signature	Patient's Printed Name	Date

I acknowledge receipt of this lien.

_____	_____	_____
Attorney Signature	Attorney's Printed Name	Date

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PERSONAL INJURY / ACCIDENT PAYMENT AGREEMENT

If you have been injured in an accident and do not carry personal health insurance or medical payments coverage on your automobile insurance, this office will await payment until 3rd party settlement is obtained, provided recovery is within one year of the last date of service.

We require patients to sign a lien on all personal injury cases to insure payment to The Concussion Place from any/all responsible parties, at the time of settlement, for the services you receive. If you do not obtain settlement or recovery from the responsible party(s) within one year, or if it appears litigation is imminent, you will be asked to make payment arrangements.

Before The Concussion Place can extend a patient credit, the patient must provide us with proof of insurance coverage. If multiple sources of coverage exist, this office will have the option of submitting directly to all insurance companies, (except third party insurance) to insure 100% reimbursement of your account to to The Concussion Place while you are receiving care.

Third party billing is done only at the patient's request and arrangements must be made in advance.

As a means of appropriating payments due this office expeditiously, patients selecting this payment option give to The Concussion Place permission to endorse their name to checks payable to both parties, by way of a limited power of attorney. I authorize and direct all insurance companies, attorneys, etc., to make direct payment to to The Concussion Place for all monies due on my account, if assignment is prohibited, I direct all payers required to make checks payable to Dr. Brad Gulla or The Concussion Place,, to mail said payments to The Concussion Place at:

The Concussion Place
3425 Austin Bluffs Parkway. Suite 105
Colorado Springs, CO 80918

_____	_____	_____
Patient Signature	Patient's Printed Name	Date

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ASSIGNMENT OF BENEFITS

Claim Number_____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

Brad Gulla, D.C.
The Concussion Place
3425 Austin Bluffs Parkway. Suite 105
Colorado Springs, CO 80918

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Brad Gulla, D.C.
The Concussion Place
3425 Austin Bluffs Parkway. Suite 105
Colorado Springs, CO 80918

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered: **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, and balance of said professional service charges over and above this insurance payment.

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

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____	_____	_____
Policy Holder Signature	Policy Holder's Printed Name	Date

_____	_____	_____
Signature of Claimant, if other than policyholder	Printed Name of Claimant, if other than policyholder	Date

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BILLING INFORMATION		
Date of Accident:		
Patient's Automotive Insurance Information		
Insurance Company:		Medical Payments Option (MedPay) Amount: $
Claim Number:		Your Auto Policy Number:
Patient's Medical Health Insurance Information		
Insurance Company:		Phone:
Policy Number:	Group Number:	ID Number:
Third Party's Automotive Insurance Information (Responsible for the Accident)		
Name of Insured:		Date of Birth:
Insurance Company:		Phone:
Claim Number:		Claim Adjusters Name:

For Office Use