PATIENT INFORMATION

Atlast Health Care Centers

(√) **PATIENT INFORMATION** ***Please Print Clearly***

Last Name ______________________ First ______________________ MI ____ Date ________

Address ____

City ______________________________ State ________________ Zip ____________

Home Phone # ______________ Cell Phone # ______________ Work Phone # ______________

Social Security # ______-_____-________ Birth Date _____/_____/_____ Age _____ Male _____ Female _____

Marital Status: ( ) Married ( ) Single ( ) Divorced / Separated ( ) Widowed

( ) **SPOUSE AND/OR MINORS (UNDER 18)**

Last Name ______________________ First __________________ Phone # ______________

Signature Authorizing Care (for parent of minor only) ______________________________

(√) **EMPLOYER INFORMATION** ( ) Not working at this time

Occupation/ Company ____

Address ____

City ______________________________ State ________________ Zip ____________

(√) **NEAREST RELATIVE NOT LIVING WITH YOU**

Name ____________________________________ Phone # ______________________

Address ____

City ______________________ State _____ Zip __________ Relationship ______________

(√) **MEDICAL HEALTH INSURANCE INFORMATION** ( ) I don't have Health Insurance

Insurance Company Name ____

Group No./ID No. ______________________ Address ______________________________

City ______________________________ State _______ Zip ____________________

(√) **AUTO INSURANCE OF THE CAR YOU WERE IN DURING ACCIDENT** ( ) Vehicle was un-insured

Policy Holder Name ____

Insurance Carrier Name ______________________________ Policy # ______________________

Address __________________________________ Claim # ______________________

Adjuster ________________________________ Phone # ______________________

Name of Responsible Insurance Carrier (Other Vehicle) ______________________________

Name of Insured ____________________Claim # ________________ Phone # ______________

( ) **WORKERS COMPENSATION INFORMATION** (Only fill out if you were involved in a work accident)

Employer's Insurance Carrier ____

Address __________________________________ City ______________________

State __________________ Zip ______________ Phone # ______________________

Claim # ________________________________Adjuster ______________________

AUTO ACCIDENT QUESTIONNAIRE

Atlast Health Care Centers

Today's date ___________

Please fill out the answers to the following questions to the best of your ability. If you have difficulty with any questions or are unsure of how best to answer, please discuss those questions with the doctor before answering.

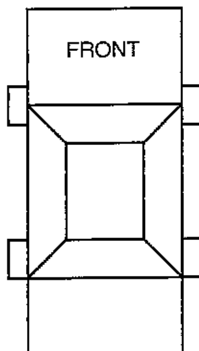
Mr. Ms. (Last) ______________________ (First) ______________________
Age: ______ Weight: ________ Height: ________
Are you:
( ) married ( ) single ( ) divorced ( ) separated ( ) widowed ( ) living with a significant other
Are you a parent? NO, YES, with 1 2 3 4 5 6 Children
Occupation ______________________ For how long ___ years ____ months
Make and model of the vehicle you were in ______________________ year ______
Date of Accident ______________

(Check One for each question)

You were:
___ the driver
___ front seat passenger
___ rear seat passenger

Your vehicle was struck:

___ in the rear
___ in the right rear
___ in the left rear
___ in the driver's side
___ in the passenger's side
___ in the front
___ in the left front
___ in the right front
other (explain below)



Draw an arrow to show where you were hit.

Your vehicle was:

___ stopped at a traffic signal
___ stopped at a stop sign
___ stopped for a pedestrian
___ stopped in traffic
___ at a complete stop
___ slowing down for a traffic signal
___ slowing down for a stop sign
___ slowing down for a pedestrian
___ slowing down for traffic
___ slowing down to turn
___ slowing down to park
___ making a right-hand turn
___ making a left-hand turn
___ making a U-turn
___ moving with the flow of traffic
other (explain below)

Your vehicle was struck by:
___ a car
___ a van
___ a pickup truck
___ a bus
___ another vehicle (what type) ______________

Damage to Your Vehicle was
a) None or almost none, b) Minimal (below 1,000), c) Significant (above 1,000), d) Extensive (3,000 or more)
Damage to the Other Vehicle was
a) None or almost none, b) Minimal (below 1,000), c) Significant (above 1,000), d) Extensive (3,000 or more)
Will a photo of the damage represent the severity of the impact very well? Yes, No

Additional Information on Collision (If the information given already does not describe the accident fully)

____

____

____

____

(Please continue on reverse side)

 Patient Name ______________________

Have you had any accidents or injuries since this accident? No, If Yes, Please explain

____

____

____

____

____

Please answer the following questions.

1) Since the accident, is there anything you have been **unable** to do? ______________________

____

2) Since the accident, is there anything you have had **difficulty** doing? ______________________

____

3) Since the accident have you been able to continue with most of your daily activities? ______________________

____

Please answer the following questions

(Please circle your answers)

Were you wearing your seatbelt? YES NO
Did your air bag deploy and hit you? YES NO
Were you: Sitting squarely in your seat, Twisted in your seat, Leaning forward, or Leaning to the side
Was your head position: Faced-forward, Turned to the left , Turned to the right, Unsure
Were you aware of the impending collision? YES NO, Braced for impact? YES, NO
Was your head and body thrown backward and forward in a forceful manner? YES, NO **or**
Was your head and body thrown from one side to the other in a forceful manner? YES, NO
Did the shoulder restraint of your seatbelt prevent you from hitting the steering wheel? YES, NO
Did you hit your head on the Steering wheel, Windshield, Visor, Roof, Side window, Headrest.
Other ______________________

Place check marks (√) to answer

Did you go
______Immediately to the hospital by ambulance
______To the hospital after the accident using your own transportation
______To the hospital, but some days later. If so, when (/ /)
______To a private physician. If so, when (/ /)

Name of hospital or Doctor? ______________________
(Request records)

Atlast Health Care Centers of Maryland, LLC
(301) 430-5263
Fax (301) 390-8791

Authorization of Rights to Health Care Provider

For the purpose of expediting the handling of my claim, I hereby grant this health care provider a durable power of attorney to execute in my name and on my behalf, any and all documents relating to my treatment and/or the payment for it, including but not limited to the execution of insurance applications, checks or drafts received pursuant to my claim, and authorizations for the release of information.

The purpose of this is to provide convenience so that I do not need to make repeated arrangements to sign and execute documents, as well as assist in my health care provider in being paid. I understand that I can decline this offer of convenience.

I further assign to this health care provider the authorization, permission and the right to obtain all information relating to my PIP benefits, including but not limited to

- Any payments made;
- Who the payees were on any such payments;
- Where and to whom any such payments were mailed;
- The date that the PIP carrier received the supporting documentation (bills, receipts, lost wage statements) for any such benefit paid out

I further assign to this health care provider the authorization, permission and right to obtain from any insurance company, including the liability carrier or uninsured motorist carrier, any and all information relating to any claim I may have. This includes but is not limited to:

- The status of such claim;
- Whether a lawsuit has been filed;
- Whether a settlement is imminent

__________________________________ ____________

Signature Date

Atlast Health Care Centers of Maryland, LLC
c/o Premiere Billing
3060 Mitchellville Rd.
Suite 106
Bowie, MD 20716
(301) 430-5263
Fax (301) 390-8791

REPORTS RELEASE AND DOCTOR'S LIEN

The following agreement:

1. Should be read and signed if you do not wish to pay for each visit at the time of the visit.
2. Will allow us to deal directly with your employer, any insurance company and/or attorney that may be involved now or in the future in the processing of payment for services rendered.
3. Will allow your employer, attorney and/or insurance company, to pay us directly if we have not been paid.
4. States that you understand all bills are your responsibility.

I do hereby authorize Atlast Health Care Centers of Maryland, LLC (Atlast) to furnish you, my employer, attorney and/or insurance company adjuster, with a full report of my examination, diagnosis, treatment, prognosis, charges incurred, etc.

I do hereby authorize and direct you, my employer, attorney and/or insurance company, to pay Atlast directly such sums as may be due and owing them for health care service rendered to me and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect Atlast. Atlast should also be paid any sum due from any funds available through Personal Injury Protection (PIP), Med Pay, health insurance or worker's compensation insurance as soon at it is available. I further give a lien on my case to Atlast against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or to me as the result of the injuries or health conditions for which I have been treated by an Atlast service provider.

I fully understand that I am directly responsible to Atlast for all medical bills submitted by them for services rendered me and that this agreement is made solely for Atlast s' additional protection and in consideration of them 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. I understand that Atlast will wait a reasonable period of time for payment. If payment is not received in a timely fashion, I will be billed directly. In the unfortunate event collection procedures are required to collect an outstanding balance, I shall be responsible for the reasonable cost (35% of the past due balance) of a collection agency, attorney, and / or court costs.

Dated:__________ Patient's Signature ______________________________________ (Seal)

Printed ______________________________________

IF APPLICABLE:

The undersigned, being attorney of record for the above patient, do hereby agree to observe all the terms of the above and agree to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect Atlast Health Care Centers of Maryland, LLC.

Dated: _______________ Attorney's Signature ______________________________________ (Seal)

- A photocopy of this form shall be considered as valid as the original.