EXPRESSIONS
Chiropractic of Dallas P.C.

601 North Akard St. Suite 202 Dallas, TX 75201 | 214-969-6999

PERSONAL INJURY INSURANCE INFORMATION

You have notified our office that you were involved in a Motor Vehicle Accident. Due to the rising costs of medical services you may not want to pay for each visit personally. As a courtesy to our patients, Dr. Fowler will defer payment on the account provided that we receive your cooperation on the following:

1) Provide the following insurance information:
- Insurance Information for the Person Responsible for the Accident
- Personal Auto Insurance
- Health Insurance
- Attorney Information (if applicable)

2) Set up Personal Injury Protection Claim (if applicable)
3) Cooperate with our office in communicating with involved insurance carriers/attorneys

INFORMATION NEEDED:
Date of Accident:_____ Were you the driver? (Please choose one):   Driver   Passenger

Description of your vehicle: (Year, Make, Model) _____

Insurance Information for at Fault:
Name of Insurance:_____ Phone:_____
Name of Insured: _____ Policy#: _____
Claim #:_____
Adjuster Name: _____ Adjuster Phone: _____

Personal Auto Insurance:
Do you have PIP(Personal Injury Protection)? Yes   No   Policy-Limit: $ _____
Name of Insurance:_____ Phone:_____
Name of Insured: _____ Policy#: _____
If applicable: Claim #: _____
Adjuster Name: _____ Adjuster Phone: _____

If you were a passenger, please provide the insurance information of person driving:
Name of Insurance:_____ Phone:_____
Name of Driver: _____ Phone:_____
Name of Insured: _____ Policy#: _____
If applicable: Claim #: _____
Adjuster Name: _____ Adjuster Phone: _____

Health Insurance:
Name of Insurance:_____ Phone:_____
Insured's Name:_____ Insured DOB: _____
Policy Number: _____ Group Number: _____

Attorney Information: (if applicable)
Attorney Name: _____
Address: _____
Phone: _____ Contact Person: _____

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Assignment of Benefits | Assignment of Cause on Action | Contractual Lien

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to Paul L Fowler, DC, and/or Expressions Chiropractic, a lien and assignment of any and all claims, causes of action, and right to any proceeds and /or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and /or payment of the medical charges incurred with all the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjustor for purposes of processing my claim for benefits and payment for services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to Expressions Chiropractic of Dallas, P.C. and to send any and all checks to 601 N Akard Street Suite 202 Dallas, TX 75201.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to Expressions Chiropractic of Dallas P.C., and to send any and all checks to 601 N Akard Street Suite 202 Dallas, TX 75201.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORYEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by me caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

Name of Patient: _____**Date of Birth:** _____

Signature of Patient and/or Responsible Parties: _____**Date:**_____