Dear Patient:

Recently, it has come to our attention that car insurance contracts will not reimburse the doctor directly for medical care received for injuries due to an automobile accident. Therefore, we are forced to amend our policy in relationship to accepting on “Med Pay” claims in automobile accident cases.

If you are undergoing treatment in the office for personal injury sustained because of an auto accident, your automobile insurance carrier will **pay you** 100% of all reasonable charges directly through your “Med Pay” portion or your contract. Therefore, our policy regarding assignment on personal injury cases has been changed as follows:

1. We do not accept as assignment the “Med Pay” portion of your automobile insurance contract, or third party legal claim unless you have an attorney involved and the attorney together with you are willing to sign a lien assignment insuring payment of our claim.
2. If you do not have an attorney that is involved in your case or is not willing to sign a lien assignment then your case will be handled in the following manner:

    a) If you have personal health insurance that we verify that will pay us directly, we will submit claims as we normally would for any insurance claim. –or-
    b) You will be a cash patient. In this case, we will accept payment by credit card, check or financial arrangement can be considered on an individual basis. All claims will be billed to your auto insurance carrier on a weekly basis.
    c) You may prepay portions of your treatment and received a cash savings discount.

Please note that by receiving this letter, it has been determined that you do not have an attorney involved in your case and / or we do not have a lien assignment on file. We would appreciate your cooperation by contacting Leslie Charles in our insurance department and make the necessary arrangements relative to your case.

Very truly yours,
R. Thomas Roselle, D.C., P.a.c.

Patient's Report of Accident

Name:____Today's Date:______________________

Location of Accident:____City:_______________________

Date of Accident:___________________Was police report made?________________________________

Were you:_____Driver Passenger ____Pedestrian Were you wearing a seat belt_________

Were you struck from: ________ Behind ______Right Side ____Left Side _____Front

Direction of your travel________ Other Car__________

Approximate speed of your car______________ Other Car__________________

Kind of car you were in________ Damage$___________ Other car____________ Damage$_____

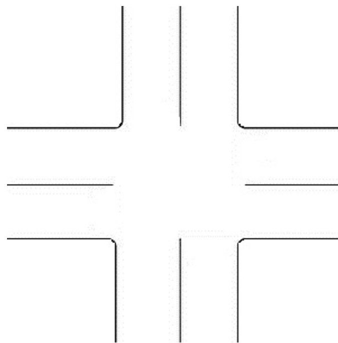
How did the accident occur?____

____

____

____

Indicate on diagram what happened



(Indicate North by Arrow)

How did you feel immediately after the accident? If the injury was not noticeable right away, when did you notice any problems?____

____

____

____

Have you received first aid or any other treatment for this injury?___________________________________

If yes, from whom?_______________________________________City________________________________

Were you hospitalized?_

If yes, how long?_____________ Name and city of hospital____

Were you off work because of this injury?_____________

If yes, when was the first day you were unable to work?____

Have you returned to work?_________________ If yes, on what date?______________________________

As a result of the accident, were traffic citations issued to you? _______Yes _______No

To the other driver? _____Yes _____No Were more than two cars involved? _____Yes _____No

Did this accident occur during your work hours? ________Yes _______No

Was this accident other than an automobile accident? ______Yes ______No

If yes, please give a full description:____

____

____

____

Did you require post-accident hospitalization? _______Yes ________No

Check symptoms you have noticed since accident:

	Headaches		Dizziness		Depression		Fatigue
	Stomach Upset		Light Bothers Eyes		Buzzing in Ears		Diarrhea
	Neck Pain		Heavy Head		Loss of Memory		Feet Cold
	Neck Stiff		Pins & Needles in arm		Ringing in Ears		Hands Cold
	Fainting		Sleeping Problem		Loss of Balance		Back Pain
	Face Flushed		Pins & Needles in leg		Constipation		Tension
	Nervousness		Numbness in Fingers		Loss of Smell		Fever
	Irritability		Numbness in Toes		Loss of Taste		
	Cold Sweats		Shortness of Breath		Chest Pain		

Symptoms other than above:____

____

Have you lost any days of work? _____________ Dates:____

Insurance Companies Involved:

My Company:____

Company of person responsible for injuries:____

Have you been contacted by an insurance adjuster or company representative regarding this claim?_____

Do you have an attorney that has advised you in this case? _______Yes _______No

Name of Attorney:_______________________________ Telephone #_____________________________

Address: ____

Multi Discipline Alternative Care Centers

8500 Executive Park Avenue, Suite 300
Fairfax, Virginia 22031
(703) 698 – 7117 FAX (703) 698-5729

To:	**Date:**
Address:	**File #:**
City, State, Zip	**D.O.A.**
Patient:	**Doctor:**

RE: **Medical Records and Doctor's Lien**

I do hereby authorize the above to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

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

Patient's Signature: ________________________________ Dated: ________________________

The undersigned being attorney for the patient does 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 said doctor above named.

Attorney's Signature: ______________________________ Dated: ________________________

Multi Discipline Alternative Care Centers, LTD

ASSIGNMENT OF PAYMENT

D.O.A.______________________

Patient:____ Phone #:__________________________

Address:____

Attorney's Name:_______________________________________ Phone #:__________________________

Address: ____

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to Multi Discipline Alternative Care Centers, LTD. Any monies due on account the same to be deducted from any settlement made on my behalf.

Further, I agree to pay Multi Discipline Alternative Care Centers, LTD the difference, if any, between the total amount of charges and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned agree to pay Multi Discipline Alternative Care Centers, LTD, the full amount of charges should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Dated at: Multi Discipline Alternative Care Centers, LTD this ______ day of_________ 20___

__________________________________ __________________________________

Witness: Patient:

PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION:

- Your car Insurance:______________________________________ Phone #:___________________

  Address: ____

  Policy Number: ___________________________ Contact Person: ___________________________

- Health Insurance:____ Phone #:___________________

  Address: ____

  Policy Number: ___________________________ Contact Person: ___________________________

- 3rd Party Insurance:______________________________________ Phone #:___________________

  Address: ____

  Policy Number: ___________________________ Contact Person: ___________________________

Multi Discipline Alternative Care Centers, LTD

(703) 698-7117   Fax: (703) 698-5729

DIRECT PAYMENT TO DOCTOR

I ______________________________reside at: ____
policy number: _____________________ hereby direct and instruct
INSURANCE COMPANY to make out a check to:

Multi Discipline Alternative Care Centers, LTD
8500 Executive Park Avenue, Suite 300
Fairfax, Virginia 22031

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

C/O: Multi Discipline Alternative Care Centers, LTD
8500 Executive Park Avenue, Suite 300
Fairfax, Virginia 22031

The professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for 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, any balance of said professional service charges over and above the insurance payment.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECT AND VALID AS THE ORIGINAL.

Dated at Roselle Center for Healing, this ______ day of ____________20____

___________________________ ________________________________
Signature of Policyholder Witness

____
Signature of Claimant, if other than Policyholder

X_______________________________________
Signature of Insurance Representative as Acknowledgement of Receipt of this Lien

NOTE: PLEASE SIGN AND FAX BACK TO (703) 698-5729