

Smith Chiropractic LLC  
10 Duff Rd STE 100  
Pittsburgh, PA 15235

### Auto Accident Form

Patient Name \_\_\_\_\_

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Please mark your involvement in the Auto Accident:       Pedestrian     Driver       Passenger

What are your current symptoms?  Pain     Numbness     Stiffness     Weakness

Date of Accident \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient was located:     Driver                       Passenger- middle front       Passenger- right front  
                                  Passenger- left rear     Passenger- middle rear       Passenger- right rear

Patient Vehicle Type:  Compact     Mid-size     Full-Size     SUV     Pick-up     Motorcycle

Second Vehicle Type:  Compact     Mid-size     Full-Size     SUV     Pick-up     Motorcycle

Third Vehicle Type:     Compact     Mid-size     Full-Size     SUV     Pick-up     Motorcycle

Road Conditions:     Clear             Dark             Dry             Foggy             Icy             Wet

Road Type:             Asphalt             Concrete         Dirt             Gravel

Were you aware the accident was going to occur?     Yes     No

Were you wearing a seatbelt?                       Yes     No

Did your airbag deploy?                       Yes     No

Does your car have a head rest?     Yes     No

What position was the head rest in?     Up       Middle     Down

Patient's Head Position:  Looking Straight Ahead     Left Level       Left Up       Left Down  
                                  Right Level       Right Up       Right Down     Looking Up     Looking Down

#### *Accident Details*

Was your car braking?     Yes     No                      Was your car moving?  Yes     No

If yes, how fast? (mph)  <5     6-10     11-15     16-20     21-30     31-40     41-50     51-60     61-70     >70

Was the second vehicle braking?     Yes     No                      Was the second vehicle moving?     Yes     No

If yes, how fast? (mph)  <5     6-10     11-15     16-20     21-30     31-40     41-50     51-60     61-70     >70

Was the third vehicle braking?     Yes     No                      Was the third vehicle moving?     Yes     No

If yes, how fast? (mph)  <5     6-10     11-15     16-20     21-30     31-40     41-50     51-60     61-70     >70

Smith Chiropractic LLC  
10 Duff Rd STE 100  
Pittsburgh, PA 15235

### Collision Details

- First Impact:**  hit by other vehicle  hit other vehicle  hit by object  hit object  
**Impact Location:**  front  front-right  front-left  left  left  right  right-rear  left-rear  rear  rear  top  top
- Second Impact:**  hit by other vehicle  hit other vehicle  hit by object  hit object  
**Impact Location:**  front  front-right  front-left  left  left-rear  left-rear  rear  rear  top  top

### Collision Results

- Body was thrown:**  Forward  Backward  Left  Right  Can't Remember
- Head Hit:**  airbag  front windshield  rearview mirror  steering wheel  
 dashboard  back of the front seat  side window/door  another person's body  headrest
- Chest Hit:**  airbag  steering wheel  dashboard  back of the front seat  
 side window/door  another person's body
- Shoulders Hit:**  shoulder harness  side window/door  back of front seat  another person's body
- Knees Hit:**  steering wheel  dashboard  back of the front seat  
 door panel  center console  another person's body
- Hips Hit:**  steering wheel  dashboard  back of the front seat  
 door panel  center console  another person's body

### Vehicle Damage

- Patent Vehicle:**  totaled  significant damage  light damage  no damage  
**Second Vehicle:**  totaled  significant damage  light damage  no damage  
**Third Vehicle:**  totaled  significant damage  light damage  no damage

### Hospitalized

Were you hospitalized?  Yes  No. If yes, please answer the questions below.

When were you hospitalized?  immediately  later same day  next day  date \_\_\_\_\_

How were you transported to the hospital?  ambulance  life flight  private transportation

What did the hospital recommend?  no instructions  see this clinic  see DC

see own doctor  see orthopedist  see neurologist  prescription medication

other: \_\_\_\_\_

Did you have any xrays taken?  Yes  No

If yes, what areas? \_\_\_\_\_



Combining Tradition and Excellence to Relieve Your Pain

Duff Office Center  
10 Duff Road, Suite 100, Penn Hills, PA 15235  
Phone (412) 243-6676 / Fax (412) 243-4992  
Email: Dr. Frank Smith, DRFAS3@aol.com  
Dr. Shannon Smith, DRSDS@aol.com  
Dr. Brian Smith, DRBJS19@aol.com

## Auto Accident Information

Please fill out and return to our front desk as soon as possible.  
Thank you!

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SS#: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Auto Insurance Name: \_\_\_\_\_

Auto Insurance Address: \_\_\_\_\_

Auto Insurance Phone: \_\_\_\_\_

Claim Number: \_\_\_\_\_

It is very important to maintain prescribed treatment plan for a timely recovery as required by your auto insurance.

### TREATMENT FOR:

- Auto/Work Comp Accidents,
- Whiplash, Lower Back Pain,
- Sciatica & Leg Pain,
- Neck & Back Pain, Headaches,
- Numbness In Hands/Feet,
- Scoliosis, Nutritional Deficiencies

### SERVICES OFFERED:

- Private Consultation & Diagnosis,
- Thorough Spinal Exams,
- Orthopedic/Neurologic Testing
- X-Ray, Therapeutic Exercise & Rehabilitation Programs,
- Vitamin & Nutritional Evaluations,
- Extremity & Spinal Injury Treatment,
- Pre-Employment Spinal Screenings,
- Workplace Ergonomics Trainings
- Scoliosis Screening.
- Patient Healthcare Seminars

### INSURANCES ACCEPTED:

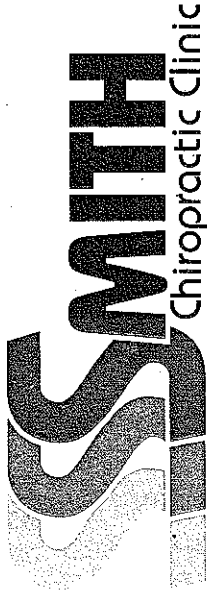
- ALL Auto/Work Comp. Insurances,
- Blue Cross/Blue Shield,
- Keystone Health Plan West HMO,
- Major Medical, Select Blue,
- Complete Care, Preferred Blue,
- Premier Blue, UPMC POS,
- Health Assurance, US Healthcare,
- United Healthcare, Mailhandlers,
- Carpenters, Travelers, MEDICARE,
- Security Blue, Highmark HMO

### OFFICE HOURS:

- Monday, Wednesday, Friday:  
9:00 am - 12:00 noon
- 2:30 pm - 7:00 pm
- Tuesday & Saturday:  
9:00 am - 12:00 noon

Dr. Frank A. Smith, Dr. Shannon David Smith, Dr. Brian J. Smith

BOARD CERTIFIED: National Chiropractic Board of Examiners, PA State Board of Chiropractic and Physio Therapy  
ADVANCED TRAINING: Spine Trauma & Whiplash, Injury Rehabilitation, Nutritional Counseling, Clinical Diagnosis, Workplace Ergonom



Combining Tradition and Excellence to Relieve Your Pain

Duff Office Center
10 Duff Road, Suite 100, Penn Hills, PA 15235
Phone (412) 243-6676 / Fax (412) 243-4992
Email: Dr. Frank Smith, DRFAS3@aol.com
Dr. Shannon Smith, DRSDS@aol.com
Dr. Brian Smith, DRBJS19@aol.com

TREATMENT FOR:

- Auto/Work Comp Accidents, Whiplash, Lower Back Pain, Sciatica & Leg Pain, Neck & Back Pain, Headaches, Numbness In Hands/Feet, Scoliosis, Nutritional Deficiencies

SERVICES OFFERED:

- Private Consultation & Diagnosis, Thorough Spinal Exams, Orthopedic/Neurologic Testing, X-Ray, Therapeutic Exercise & Rehabilitation Programs, Vitamin & Nutritional Evaluations, Extremity & Spinal Injury Treatment, Pre-Employment Spinal Screenings, Workplace Ergonomics Training, Scoliosis Screening, Patient Healthcare Seminars

INSURANCES ACCEPTED:

- ALL Auto/Work Comp. Insurances, Blue Cross/Blue Shield, Keystone Health Plan West HMO, Major Medical, Select Blue, Complete Care, Preferred Blue, Premier Blue, UPMC POS, Health Assurance, US Healthcare, United Healthcare, Mailhandlers, Carpenters, Travelers, MEDICARE, Security Blue, Highmark HMO

OFFICE HOURS:

- Monday, Wednesday, Friday: 9:00 am - 12:00 noon, 2:30 pm - 7:00 pm
Tuesday & Saturday: 9:00 am - 12:00 noon

ATTORNEY LIEN

I hereby authorize the above doctor 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 or injury I suffered.
I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for professional services rendered me both by reason of this accident and 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 adequately to protect said doctor.
Further, I hereby acknowledge that I am on immediate notice of and understand my rights under the Workers' Compensation Act, specifically, 77 P.S. § 531(f)(1)(7), relating to the prohibition against said doctor holding me liable for costs related to care or service rendered in connection with a compensable injury as may be determined by a Utilization Review Organization, and/or the Motor Vehicle Financial Responsibility Law, specifically, 75 Pa. C.S. § 1797(b)(7), relating to the prohibition against said doctor collecting payments from me for medically unnecessary treatment, services or merchandise as may be determined by a Peer Review Organization or court.

By signing this document, I have evidenced my actual knowledge and understanding of my rights under and I hereby expressly and unequivocally acknowledge and waive any and all rights that I may have under either, or both, the Workers' Compensation Act (77 P.S. § 531(f)(1)(7)) and the Motor Vehicle Financial Responsibility Law (75 Pa. C.S. § 1797(b)(7)).

As such, I hereby 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, notwithstanding any and all rights that I may have under either, or both, the Workers' Compensation Act, 77 P.S. § 531(f)(1)(7), and the Motor Vehicle Financial Responsibility Law, 75 Pa. C.S. § 1797(b)(7). I hereby further acknowledge that this authorization could be construed as contravening certain rules, regulations and common law of the Commonwealth of Pennsylvania relating to the prohibition against private contracting for medically unnecessary services and, accordingly, I hereby waive my respective rights to challenge the validity or enforceability of this authorization or any term hereof based, directly or indirectly, on any such contravention or alleged contravention.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for service 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.

In the event my first party benefit auto insurance limits are exhausted, or my workers compensation coverage for medical benefits is terminated for any reason, I expressly agree to pay doctor his customary and reasonable charges for such services, and I hereby waive any and all rights I may have limiting doctor's fees to statutorily established fee schedules.

Doctor's forbearance and agreement not to collect fees for medical services until the patient's automobile accident case settles shall toll the statute of limitations for any breach of contract or other claim Doctor may pursue against patient in the event either patient or his/her attorney refuses or fails to pay Doctor's bills in full from the settlement proceeds. The accrual date for purposes of the statute of limitations is the date patient or his/her attorney notifies Doctor in writing that the automobile accident case has settled. If the case does not settle and is either dropped by patient or proceeds to trial, the accrual date for purposes of the statute of limitations is the later of (a) the date patient or his/her attorney notifies Doctor in writing the case has been dropped, or (b) the date patient or his/her attorney notifies Doctor in writing of a jury verdict or other final disposition of the case by the trial court.

Notwithstanding any other form or agreement to the contrary, the terms of this Lien Agreement shall control and shall supersede any other such agreement or form.

Medical necessity of care provided by Doctor to patient shall not be a condition precedent to patient's obligation to pay Doctor in full for all services rendered.

In the event either patient or his/her attorney fails or refuses to pay the full amount of Doctor's services due, patient promises to pay Doctor legal interest on the amount due and owing, together with all collection costs, attorneys fees and witness fees that may be required to effect collection.

Witness

Patient Signature

Date

Author: Attorney Charles I. Artz

Dr. Frank A. Smith, Dr. Shannon David Smith, Dr. Brian J. Smith
BOARD CERTIFIED: National Chiropractic Board of Examiners, PA State Board of Chiropractic and PhysioTherapy
ADVANCED TRAINING: Spine Trauma & Whiplash, Injury Rehabilitation, Nutritional Counseling, Clinical Diagnosis, Workplace Ergonomics