ACCIDENTAL INJURY REPORT

Name_____ Today's Date _____

Date of Accident_____ Time of Accident _____ AM PM

Location of Accident _____

Type of Accident: ❑ Auto/Traffic ❑ Work/On Job ❑ At Home ❑ Other

Describe how the accident happened in your own words: _____

_____

_____

_____

Immediately following the accident, how did you feel? _____

How did you feel the next day? _____

Were you unconscious? ❑ Yes ❑ No In a daze? ❑ Yes ❑ No Did you go to the hospital? ❑ Yes ❑ No

If you went to the hospital. When? At time of accident ❑ Yes ❑ Next Day? ❑ Yes ❑ No Other? _____

How did you get to the hospital? Ambulance ❑ Yes ❑ No Private Transportation ❑ Yes ❑ No

Did the ambulance attendants place you in: Neck Collar ❑ Yes ❑ No Splints ❑ Yes ❑ No Brace ❑ Yes ❑ No

Name of Hospital:_____ Attended by Dr.: _____

Were you x-rayed at hospital? ❑ Yes ❑ No If so, what was the diagnosis? _____

_____ Were you admitted to the hospital ❑ Yes ❑ No

How long did you stay?_____ What treatment was rendered? _____

What recommendations were made? _____

List any other doctors you have seen as a result of this accident: _____

_____

Have you lost any time from work because of this accident? ❑ Yes ❑ No If yes, give dates of disability:

Totally disabled from_____ to_____ Partially disabled from_____ to _____

Have you returned to work since the accident? ❑ Yes ❑ No Please complete the following:

Date	Employer	Occupation	Light Duty/Reg. Duty	Full Time/Part Time

_____

_____

_____

Since this accident occurred, are your symptoms: Improving ❑ Yes ❑ No Getting Worse ❑ Yes ❑ No Same ❑ Yes ❑ No

Do you notice any activity restrictions as a result of this injury? ❑ Yes ❑ No Please describe: _____

_____

_____

Have you been contacted by an insurance adjuster or company representative about this accident? ❑ Yes ❑ No

If so, name, Phone # of person contacting you: _____

Have you retained an attorney? ❑ Yes ❑ No Date attorney retained or to be retained: _____

Attorney's Name:_____ Phone: _____

Address: _____

City:_____ State_____ Zip_____

Were there any witnesses? ❑ Yes ❑ No Name(s) _____

Other pertinent information: _____

_____

_____

Patient's Signature:_____ Date: _____

Please complete the questions on the backside in the category of accident you had.

AHC-039

ADVANTAGE HEALTHCARE OF SPARTANBURG
P. O. BOX 41
SPARTANBURG, SC 29304
(864) 574-6840 FAX (864) 587-8227

CLAIM # OR SS#: _____

I _____ ***do hereby give*** _____
Permission to make payment directly to ADVANTAGE HEALTHCARE OF SPARTANBURG for payment of my medical bills for services rendered as a result of any injuries/accidents on _____.

Claimant: _____ ***Date:*** _____

Witness: _____ ***Date:*** _____

original

ADVANTAGE HEALTHCARE OF SPARTANBURG
P.O. Box 41 • 1230 John B. White Sr. Blvd. • Spartanburg, SC 29304
(864) 574-6840 • Fax (864) 587-8227

ASSIGNMENT OF PROCEEDS, LIEN AND AUTHORIZATION

I hereby authorize and direct my and all insurance carriers, attorney, agencies, governmental departments, companies, individuals and/or legal entities ("payer"), which may elect or be obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future ("condition") to pay directly and exclusively in the name of ADVANTAGE HEALTHCARE such sums as be owing to ADVANTAGE HEALTHCARE for charges incurred by me at the office relating to my condition ("charges"), with such payments to be made exclusively in the name of ADVANTAGE HEALTHCARE. I further grant a lien to ADVANTAGE HEALTHCARE with respect to my charges. This lien shall apply to all payers and to the full extend permitted by law. For the purposes of this document (herein, "Assignment and Lien"), "benefits" shall include, but not be limited to, proceeds from any settlement, release agreement, judgement, verdict, or attorney benefits, personal injury protection, no-fault coverage, uninsured and under-insured motorist coverage, third-party liability coverage, disability benefits, workers' compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein, whether in compensation for medical expenses or any other type of damage recognized by law.

In the event that I retain one or more attorneys to represent me in this matter who are not located in South Carolina, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed consent of this office.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Assignment and Lien. I further authorize and direct all payers to release to ADVANTAGE HEALTHCARE any information regarding any coverage for benefits which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims. I hereby direct this office to file a copy of the Assignment and Lien, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payees. I hereby authorize ADVANTAGE HEALTHCARE to endorse/sign my name on any and all checks listing me as a payee which are presented to this office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize ADVANTAGE HEALTHCARE to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due ADVANTAGE HEALTHCARE for their services. This Assignment and Lien does not constitute any consideration for this office to await payments and it may demand payments immediately upon rendering services at its option. If this office must take any action to collect an outstanding balance of my account, I will be responsible for payment and will reimburse ADVANTAGE HEALTHCARE for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Assignment and Lien shall not be modified or revoked without the mutual written consent of ADVANTAGE HEALTHCARE and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Assignment and Lien.

DATE _____

PATIENT SIGNATURE _____

PARENT/GUARDIAN SIGNATURE _____

WITNESS _____

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