PEARSON
CHIROPRACTIC & REHABILITATION

pearsonchiropractic.com

WELCOME

The doctors and staff of Pearson Chiropractic & Rehabilitation welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical exam to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient, but will refer you to another health care provider, if appropriate. PLEASE PRINT CLEARLY!

PATIENT INFORMATION (PLEASE PRINT)

Name (First, Middle, Last) _____ Name you like to be called _____ Date of Birth _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Race:_____

Address _____ City _____ State _____ ZIP _____

Social Security Number **(REQUIRED)** _____ Home Phone _____ Mobile Phone _____ Work Phone _____

Emial Address **(REQUIRED)** _____

EMPLOYMENT INFORMATION

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Part Time Student ☐ Full Time Student ☐ Other_____

Employer _____ Occupation _____

RESPONSIBLE PARTY INFORMATION - If you are over age 18, please indicate self as responsible party

Name (if other than self) _____ Relationship to Patient _____ Responsible Party Phone _____

Responsible Party Address _____ City _____ State _____ ZIP _____

EMERGENCY CONTACT

Emergency Contact Name _____ Relationship to Patient _____ Emergency Contact Phone _____

INFORMATION ABOUT YOUR INJURY OR ILLNESS

Is your illness/injury related to any of the following?

☐ Employment ☐ Emergency ☐ Accident ☐ Auto Accident—state accident date _____

If employment related, has your employer been notified? ☐ Yes ☐ No

REFERRAL INFORMATION

How were you referred to our office? ☐ By an Attorney ☐ By a Doctor ☐ By a Patient ☐ On Social Media

☐ Google ☐ Pearson Website ☐ Office Location ☐ Other _____

Name of Referral Source _____

ACCEPTANCE AS A PATIENT

I understand and agree that the doctors of Pearson Chiropractic & Rehabilitation have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient. By submitting your phone number, you are authorizing us (opting in) to send you text messages and notifications. Message/data rates apply. Reply STOP2END to unsubscribe to a message sent from us.

Signature _____ Date _____

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PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient _____ Date _____

Signature _____

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FINANCIAL POLICY

The following is an explanation of our clinic policy. We believe that a clear definition of our policy will allow us both to concentrate on the big issue: re-establishing, retaining and maintaining your health. We will be happy to answer any questions you have regarding our policy, your account and your insurance coverage.

Payments
At Pearson Chiropractic your health care needs are our primary concern. We do not want finances to get in the way of you getting the health care that you need. Policies are in place in an attempt to assist you in meeting your financial obligations without increasing stress in your life.

- **If you do not have insurance ALL payments are expected at the time of service. Prepayments are also allowed.**
- **If you have insurance ALL COPAYS & CO-INSURANCE are due at time of service. By taking care of this while you are in the office the need for an invoice is minimized.**
- **There will be a 1% finance charge added to all balances after 60 days. Maximum charge is 12% per year.**
- **There will be a $25.00 charge on all returned checks.**
- **If you need any additional documentation other than a receipt please feel free to ask the front desk as we are able to provide that to you at no additional charge.**

Insurance Coverage
Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment. If claims denial is received after the insurance has processed, the balance will be Patient Responsibility.

Statements are sent via text or e-mail. We will not bill your health insurance for personal injury claims unless it is specified on the Motor Vehicle Accident authorization paperwork.

X-rays
We will release your X-rays to another doctor only after you sign a release/transfer form & your account has been paid in full, unless you have been referred for a consultation. We need 48 hours notice to enable us to mail X-rays in time for your appointment.

Appointment/Treatment
Pearson Chiropractic is a very busy clinic and when an appointment is scheduled for you we reserve that time for you only. There will not be a fee for rescheduling or canceling an Adjustment. ***However, for Massage Therapy, there is a $100 fee, for Rehab there is a $50 fee and for Acupuncture there is a $100 fee, if an appointment is not cancelled more than 24 hours in advance. A credit card must be on file for ALL PATIENTS, no exceptions. The credit card will be on file and charged automatically if there is a no-show or cancellation less than 24 hours in advance.***

Release and Wellness
If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

I have read and understand Pearson Chiropractic's office policies and I will honor them.

Patient's Printed Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Credit card on file with us:

Card# _____ Exp Date: _____

Name as it Appears on Card: _____

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HISTORY CHECKLIST

Patient Name _____ No. _____

Doctor _____ Date _____

Date of Birth _____ Claim No. _____

System Review (Have you had any problems with or treatment of any of the following? If yes, please describe.)

ALL PATIENTS		
Do you get dizzy when you turn your head and look back?	☐ Yes ☐ No	
Thyroid	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Head/Brain	☐ Yes ☐ No	
Eyes/Ears/Nose/Throat	☐ Yes ☐ No	
Lungs	☐ Yes ☐ No	
Heart/Blood Pressure	☐ Yes ☐ No	
Stomach/Bowel	☐ Yes ☐ No	
Bladder/Kidney	☐ Yes ☐ No	
Prostate	☐ Yes ☐ No	
Skin	☐ Yes ☐ No	
Nerves	☐ Yes ☐ No	
Medications	☐ Yes ☐ No	
Psychiatric	☐ Yes ☐ No	
Blood/Lymph/Immune System	☐ Yes ☐ No	

FEMALE PATIENTS ONLY		
Are your pregnant?	☐ Yes ☐ No	Date of last menses:
Are you taking birth control pills or shots?	☐ Yes ☐ No	
Thickening of the breast or breast pain?	☐ Yes ☐ No	
Vaginal bleeding or discharge?	☐ Yes ☐ No	

Past Medical History (Have you had any of any of the following? If yes, please describe.)

Cancer	☐ Yes ☐ No	
On the job injuries	☐ Yes ☐ No	When? Which body part?
Motor vehicle accident	☐ Yes ☐ No	When?
Other injuries	☐ Yes ☐ No	
Illnesses	☐ Yes ☐ No	
Hospitalizations	☐ Yes ☐ No	
Surgeries	☐ Yes ☐ No	
Allergies	☐ Yes ☐ No	
Implants or Joint Replacements	☐ Breast ☐ Knee ☐ Hip ☐ Other (specify)	

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Family History (Did your mother or father have any of the following? Put an **M** for mother, **F** for father, **B** for both)

_____ High Blood Pressure
_____ Heart Attack
_____ Emphysema
_____ Seizures/Convulsions
_____ HIV Positive
_____ Asthma
_____ Diabetes
_____ Kidney Disease
_____ Pacemaker
_____ Ulcer or Stomach Problems
_____ Stroke
_____ Arthritis-Rheumatism
_____ Mental Illness
_____ Thyroid Disease
_____ Circulation Problems
_____ Cancer
_____ Osteoporosis

Social History

What level of education have you completed? ☐ Elementary ☐ Jr. High ☐ High School ☐ College (2 year) ☐ College (4 year)

Have you served in the military? ☐ Yes ☐ No Where?_____

What is your occupation?_____ Are you retired? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No How much per week?_____

Do you use alcohol? ☐ Yes ☐ No How much per week?_____

What are your hobbies?_____

Other Medical Information

Do you have chest pain? ☐ Yes ☐ No
Do you have a sore on your skin that does not heal? ☐ Yes ☐ No
Do you have a nagging cough or hoarseness? ☐ Yes ☐ No
Do you have night sweats? ☐ Yes ☐ No
Do you have pain in or numbness your jaw or face? ☐ Yes ☐ No
Do you have a drooping eyelid or and change in your pupils? ☐ Yes ☐ No
Do you have any nausea or vomiting? ☐ Yes ☐ No
Do you have any slurred speech? ☐ Yes ☐ No
Have you noticed changes in your balance? ☐ Yes ☐ No

Have you noticed changes in your memory? ☐ Yes ☐ No
Do you have any ringing in your ears? ☐ Yes ☐ No
Does your pain ever wake you from a sound sleep? ☐ Yes ☐ No
Are you losing weight now without trying? ☐ Yes ☐ No
Are you coughing up blood or noticing it in your stools or urine? ☐ Yes ☐ No
Have you lost consciousness recently? ☐ Yes ☐ No
Are you seeing any other doctor for any other reason? ☐ Yes ☐ No

Note:_____

Comments

I certify that the information I give is correct to the best of my knowledge. I will not hold the doctors or staff responsible for any errors or omissions that I may have made and I authorize this office to provide chiropractic care.

Print Patient Name _____ Date _____

Patient Signature _____

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SUBJECTIVE REPORT

Date _____

Name _____

WHEN did the pain start? _____

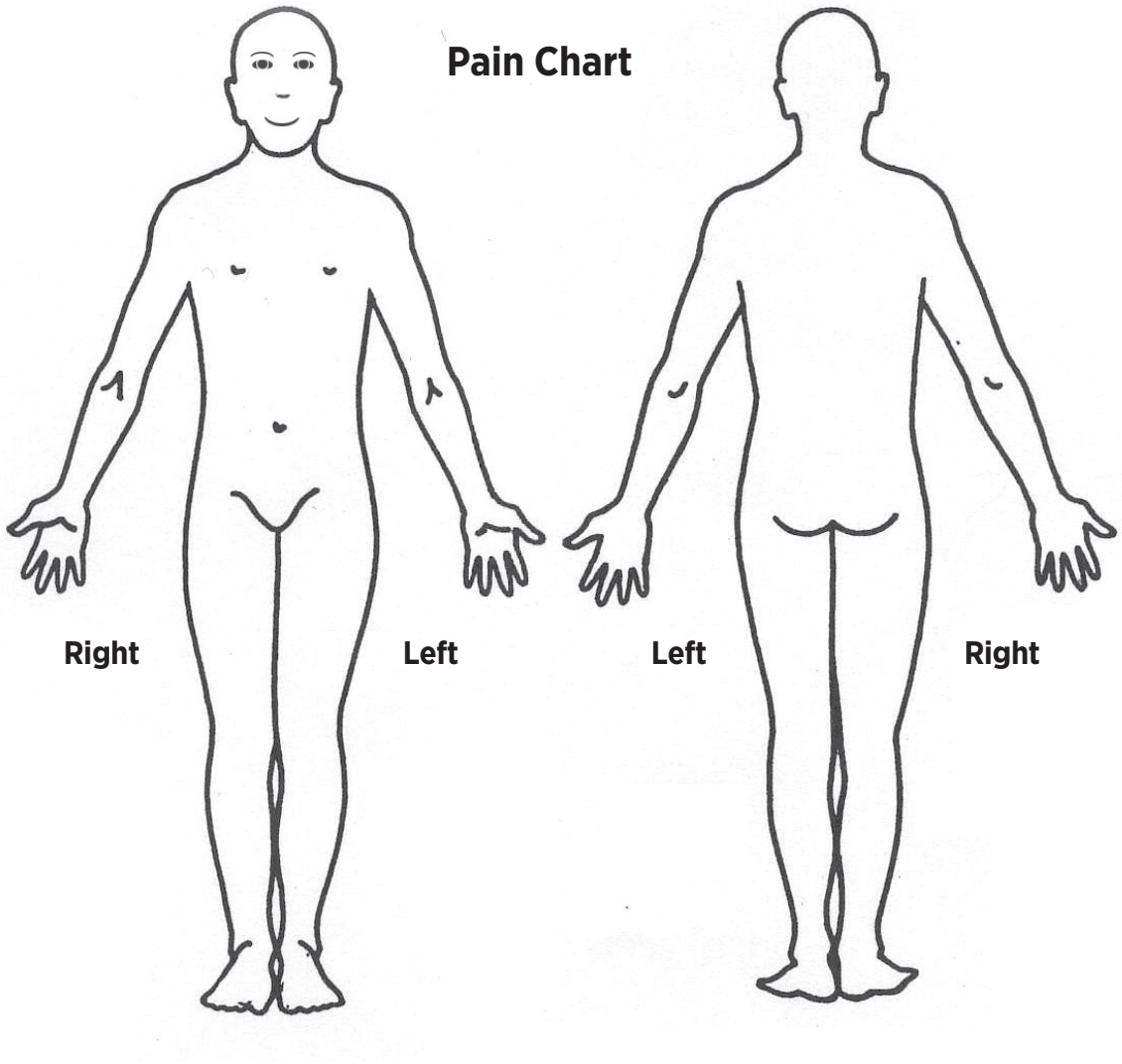
HOW did the pain start? _____

_____

_____

_____

On the body diagrams below, please circle all areas in which you have pain.
Then place a number for your level of pain inside the circle. **1** is good and **10** is your worst pain ever.



Date _____ Signature _____

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INFORMED CONSENT

Patient Name

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination and treatment, you are consenting to the following procedures:

Spinal manipulative therapy	Postural analysis
Range of motion testing	Hot/cold therapy
Muscle strength testing	Vital signs
Radiographic studies	Palpation
Basic neurological testing	Myofascial Release Therapy
Orthopedic testing	Mechanical Traction

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this growth may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW.

I have read ☐ or have had read to me ☐ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with _____and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date

Patient's Name (Printed)

Patient's Signature

Signature of Parent or Guardian (if a minor)

Date

Doctor's Name (Printed)

Doctor's Signature

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MOTOR VEHICLE ACCIDENT INFORMATION

Patient Name _____ Today's Date _____

General Information

DATE OF ACCIDENT		
_____ / _____ / _____	☐ Patient was the driver—seated in driver's seat	
	☐ Patient was a passenger	**Location:** ☐ Front Seat ☐ Middle Seat ☐ Back Seat
		Position: ☐ Left Side ☐ Middle ☐ Right Side

PATIENT'S VEHICLE	**Type**	☐ Car ☐ Van ☐ Pickup ☐ Truck ☐ Bus ☐ SUV ☐ Motorcycle ☐ Other _____
	Size	☐ Mini ☐ Subcompact ☐ Compact ☐ Mid Size ☐ Full Size
	Action	☐ Stopped ☐ Slowing ☐ Accelerating ☐ Cruising
	Speed (MPH)	**Number of other people in your vehicle**
	Time of Accident	☐ Dawn ☐ Daylight ☐ Dusk ☐ Dark
	Road Conditions	☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice
	Visibility	☐ Good ☐ Fair ☐ Poor
	Damage	☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled ☐ Unsure $ _____
	Impact Location	☐ Front ☐ Rear ☐ Side ☐ Left ☐ Right ☐ Other _____

Enter impact information for up to three vehicles or objects.

Impact #1 Information: Object or Vehicle

☐ **Object**	**Name of Object**	
☐ **Vehicle**	**Vehicle Type**	☐ Car ☐ Van ☐ Pickup ☐ Truck ☐ Bus ☐ SUV ☐ Motorcycle ☐ Other _____
	Vehicle Size	☐ Mini ☐ Subcompact ☐ Compact ☐ Mid Size ☐ Full Size
	Damage	☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled ☐ Unsure
	Impact Location	☐ Front ☐ Rear ☐ Side ☐ Left ☐ Right ☐ Other _____

Impact #2 Information: Object or Vehicle

☐ **Object**	**Name of Object**	
☐ **Vehicle**	**Vehicle Type**	☐ Car ☐ Van ☐ Pickup ☐ Truck ☐ Bus ☐ SUV ☐ Motorcycle ☐ Other _____
	Vehicle Size	☐ Mini ☐ Subcompact ☐ Compact ☐ Mid Size ☐ Full Size
	Damage	☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled ☐ Unsure
	Impact Location	☐ Front ☐ Rear ☐ Side ☐ Left ☐ Right ☐ Other _____

Impact #3 Information: Object or Vehicle

☐ **Object**	**Name of Object**	
☐ **Vehicle**	**Vehicle Type**	☐ Car ☐ Van ☐ Pickup ☐ Truck ☐ Bus ☐ SUV ☐ Motorcycle ☐ Other _____
	Vehicle Size	☐ Mini ☐ Subcompact ☐ Compact ☐ Mid Size ☐ Full Size
	Damage	☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled ☐ Unsure
	Impact Location	☐ Front ☐ Rear ☐ Side ☐ Left ☐ Right ☐ Other _____

During Impact Information

Was your seat belt on?	☐ Yes ☐ No	Were the brakes applied?	☐ Yes ☐ No
Did the airbag deploy?	☐ Yes ☐ No	Was your seat broken?	☐ Yes ☐ No
Did your seat back position change?	☐ Yes ☐ No	Did you hit your head?	☐ Yes ☐ No

During Impact Information continued

Head rest position:	☐ Low ☐ Medium ☐ High ☐ No head rest
Did you prepare for the accident?	☐ Unexpected ☐ Expected ☐ Expected and braced
What was your body position?	☐ Straight ☐ Rotated Left ☐ Rotated Right ☐ Unsure ☐ Other _____
Was your body thrown during the accident?	☐ Yes ☐ No
Head position at the time of the accident	☐ Straight ☐ Rotated Left ☐ Rotated Right ☐ Unsure ☐ Other _____
Did you lose consciousness? ☐ Yes ☐ No	For how long?

Body Impact Information

☐ Head ☐ Upper Front Torso ☐ Right Arm ☐ Right Knee ☐ Left Foot
☐ Left Shoulder ☐ Upper Back ☐ Right Elbow ☐ Left Knee ☐ Other _____
☐ Left Arm ☐ Left Leg ☐ Right Hand ☐ Lower Front Torso _____
☐ Left Elbow ☐ Right Leg ☐ Mid Torso ☐ Lower Back
☐ Left Hand ☐ Right Shoulder ☐ Mid Back ☐ Right Foot _____

After Accident Information

Were the police notified? ☐ Yes ☐ No

Immediately after the accident, how did you feel? ☐ Dizzy/dazed ☐ Upset ☐ Weak ☐ Nervous ☐ Headache
☐ Disoriented ☐ Other _____

PAIN: (Indicate if you experienced any pain in these areas immediately following the accident)

☐ Head ☐ Left Hand ☐ Right Shoulder ☐ Mid Back ☐ Right Foot
☐ Neck ☐ Upper Front Torso ☐ Right Arm ☐ Right Knee ☐ Left Foot
☐ Left Shoulder ☐ Upper Back ☐ Right Elbow ☐ Left Knee ☐ Other_____
☐ Left Arm ☐ Left Leg ☐ Right Hand ☐ Lower Front Torso
☐ Left Elbow ☐ Right Leg ☐ Mid Torso ☐ Lower Back _____

NUMBNESS: (Indicate if you experienced any numbness in these areas immediately following the accident)

☐ Left Hand ☐ Left Leg ☐ Left Upper Arm ☐ Left Foot ☐ Other_____
☐ Right Hand ☐ Right Leg ☐ Right Upper Arm ☐ Right Foot

Medical Care

Did you get medical care for this accident before coming to our office? ☐ Yes ☐ No

Time of care	☐ Immediately ☐ Later that day ☐ Next day ☐ Days later: Number of days_____
Transported by	☐ Drove myself ☐ Ambulance ☐ Other _____
Type of doctor you saw	☐ Orthopedist/Chiropractor ☐ Neurologist ☐ Family Doc ☐ ER ☐ Other _____
Admitted to the hospital?	☐ Yes ☐ No
Tests performed	☐ X-Ray ☐ Lab work ☐ MRI ☐ CT Scan ☐ Other _____
Treatment given	☐ Ice Pack ☐ Hot Pack ☐ Cervical Collar ☐ Medication ☐ None ☐ Other _____

Previous Injuries

Have you suffered previous accidents or injuries? ☐ Yes ☐ No

If yes, please specify: _____

Do you have residual pain from previous accidents or injuries? ☐ Yes ☐ No

If yes, please specify: _____

Have you lost time from work as a result of this accident? ☐ Yes ☐ No If yes, what was the last day you worked? _____

What type of work do you do? _____

Later Symptoms (Please note any symptoms that started AFTER the accident occurred)

HEAD

- ☐ Headache
- ☐ Fainting
- ☐ Dizziness
- ☐ Memory Loss
- ☐ Blurred Vision
- ☐ Ear Pain
- ☐ Light-headedness
- ☐ Double Vision
- ☐ Loss of Vision
- ☐ Bump, Bruise, Laceration
- ☐ Other _____

NECK

- ☐ Radiating Pain in Shoulders or Arms
- ☐ Neck Pain
- ☐ Muscle Spasms
- ☐ Popping in Neck
- ☐ Other _____

SHOULDERS

- ☐ Shoulder joint pain
- ☐ Pain across shoulder
- ☐ Tension in shoulders
- ☐ Muscle spasms in shoulder
- ☐ Can't raise arms above shoulder level
- ☐ Can't raise arms over head
- ☐ Other _____

ARMS AND HANDS

- ☐ Pain in arms
- ☐ Pain in fingers
- ☐ Cold hands
- ☐ Loss of grip strength
- ☐ Pins & needles in hands
- ☐ Pins & needles in fingers
- ☐ Swollen joints in fingers
- ☐ Numbness in left arm
- ☐ Numbness in right arm
- ☐ Other _____

CHEST

- ☐ Chest pain
- ☐ Breast pain
- ☐ Pain around ribs
- ☐ Shortness of breath
- ☐ Other _____

ABDOMEN

- ☐ Nervous stomach
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal Pain
- ☐ Other _____

MID BACK

- ☐ Sharp stabbing
- ☐ Pain
- ☐ Muscle spasms
- ☐ Pain from front to back
- ☐ Pain between shoulders
- ☐ Other _____

LOWER BACK

- ☐ Sharp stabbing
- ☐ Pain
- ☐ Muscle spasms

Low back pain is worse when:

- ☐ Working
- ☐ Sitting
- ☐ Lifting
- ☐ Bending
- ☐ Stooping
- ☐ Coughing
- ☐ Standing
- ☐ Lying down
- ☐ Other _____

HIPS, LEGS AND FEET

- ☐ Pain in buttocks
- ☐ Pain in hip joint
- ☐ Numbness in toes
- ☐ Leg cramps
- ☐ Pins & needles in legs
- ☐ Feet feel cold
- ☐ Numbness in leg
- ☐ Pain down leg
- ☐ Knee pain
- ☐ Other _____

GENERAL

- ☐ Nervousness
- ☐ Irritability
- ☐ Fatigue
- ☐ Depression
- ☐ Cramping
- ☐ Generally feeling run down
- ☐ Sleep loss: _____ hours per night
- ☐ Other: _____

COVINGTON
253.638.2424
15610 SE 272nd Street
Suite A-106
Covington, WA 98042

FEDERAL WAY
253.838.1441
1426 S 324th Street
Suite B115
Federal Way, WA 98003

AUBURN
253.329.2718
7084 Lakeland Hills Wy, SE
Suite 107
Auburn, WA 98092

MAPLE VALLEY
425.432.4621
27203 216th Ave, SE
Suite 1
Maple Valley, WA 98038

SPANAWAY
253.539.0132
129 176th Street, S
Suite A
Spanaway, WA 98387

SCAN FOR MORE INFO ABOUT US!

PEARSON
Chiropractic & Rehabilitation
www.pearsonchiropractic.com

AUTO INSURANCE BILLING

If you wish to bill auto insurance, a third party or an attorney for injuries received due to an accident, ***the following questions must ALL be completed fully.***

This Section Pertains to You, Your Auto Insurance and Your Car

Your Name

Your Auto Insurance Claims Office Name

Your Claims Office Address

City State ZIP Phone

Insured Person's Name Policy No. Claim No.

Accident Date Accident Time Accident Location

Make and model of the car you were in

Which side of the car was damaged?

Did the other car strike your car? ☐ Yes ☐ No ☐ Undetermined Were you at fault or issued a citation? ☐ Yes ☐ No

This Section Pertains the Driver(s) of the Other Vehicle(s)

Driver's Name

Auto Insurance Claims Office Name

Claims Office Address

City State ZIP Phone

Insured Person's Name Policy No. Claim No.

Make and model of the other driver(s)' car

Was the other driver at fault? ☐ Yes ☐ No Was the other driver issued a citation? ☐ Yes ☐ No

Your Attorney's Information

Have you retained an attorney? ☐ Yes ☐ No

Attorney's Name

Attorney's Office Address

City State ZIP Phone

This information must be ***complete in full***. Even if you were not at fault, we still need ***your*** auto insurance information completed to determine if you have Personal Injury Protection (P.I.P.) coverage, which is a provision on your policy to pay for medical bills until the time of settlement with the other involved parties' insurance company, who then reimburses your insurance company fully. If applicable, please understand that this is a benefit you pay for, and this is its purpose; in no way will it affect your insurance premium.

Signature Date

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PEARSON
CHIROPRACTIC & REHABILITATION pearsonchiropractic.com

MVA AUTHORIZATION

I, _____ authorize Pearson Chiropractic to bill my Personal Injury Protecton through:

Auto Insurance Carrier _____

Claim Number _____

If there is no PIP available, please bill: (choose one)

Health Insurance Carrier _____

ID# _____ Group #_____

OR

Hold for Settlement with Attorney_____

Phone # _____

OR

Third Party_____

Claim Number_____

*** Third Party***

I agree to allow Pearson Chiropractic to communicate with the third-party insurance company on my behalf to assist in claims processing. In addition I agree to have the insurance company directly pay:

Pearson Chiropractic
15610 SE 272nd Street, Suite A-106
Kent, WA 98042

for the treatment provided relating to this auto injury claim.

Signature: Date: