DeFalco Family Chiropractic

32 Auburn Street • Auburn, Massachusetts 01501
Phone (508) 832-2396 • Fax (888) 648-5635 •
www.DeFalcoChiropractic.com

NOTICE OF IRREVOCABLE LIEN AND ASSIGNMENT OF BENEFITS
AUTHORIZATION FOR RELEASE OF TREATMENT RECORDS

PROVIDER'S LEGAL & EQUITABLE LIEN-ATTORNEY'S ACCEPTANCE

Name of Practice & Provider: ____

Patient Name and Address: ____

____

Name of Insured (PIP):___________________________ Name of Insurer (PIP):____________________________

Date of Injury/Illness: ____

Name of Insured(s) (BI):__________________________ Name of Insurer(s) (BI): _________________________

Name of Law Office & Attorney: ____

In consideration of the agreement of the Provider named above to provide me with injury treatment services, I hereby to the extent of my treatment bills irrevocably assign to my Provider all my right, title and interest to and in all applicable insurance and indemnification reimbursement benefits of applicable insurance companies including but not limited to: automobile PIP (Personal Injury Protection) coverage; Medical Payment Coverage and health care coverage to which I may be entitled to pay my Provider for services rendered to treat me on and after the above date in connection with my injury or illness.

I further grant to my Provider an irrevocable Equitable Lien and an Official Legal Lien as set forth in Ch111§70A through Ch111§70D Mass. General Laws to and in any insurance benefits that may be due me and I furthermore authorize my Provider to provide my attorney and any applicable insurance companies involved with a full report concerning my condition and treatment, including but not limited to office notes, dates of visits, and charges incurred.

I hereby authorize and direct any and all applicable insurance companies to make immediate payment directly to my said Provider for all benefits and sums due me that may be due him or her upon receipt by you of my Provider's itemized statement for treatment services rendered to me.

It is further agreed that payment by any insurance company involved as herein directed to my Provider of any itemized statement shall be considered the same as if paid by the insurer directly to me.

I am aware that I remain personally responsible to my Provider for the full amount of my unpaid treatment bills and further direct any Attorney representing me to withhold from the proceeds upon any final settlement or

final disposition of my case an amount equal to that to pay any outstanding unpaid balance of my bills. This includes any balance due as a result of an independent medical exam that discontinued my personal injury protection benefits and/or my medical payments benefit.

Patients Signature____ Date: ______________________

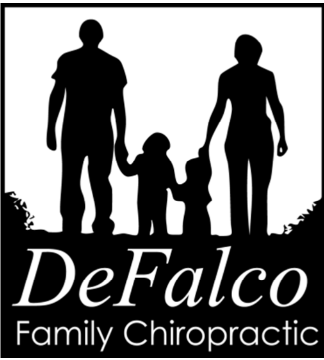
Parent/Guardian Signature: __________________________________ Date: ______________________

AGREEMENT OF ATTORNEY

I hereby agree to honor the above irrevocable Lien and Assignment and pay the Provider all sums received by me from insurers attributable to the Provider’s bills and also agree to pay the Provider any lawful balance due from the proceeds of any settlement or recovery.

Attorney’s Signature____ Date: ______________________

A photocopy of this form can be accepted with the same authority as the original



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Verification of Claims Form

Patient Name: ____

Name of Guardian (if a minor): ____

Name of Insurance Company: ____

Insurance Co. Address (PIP carrier): ____

City: _________________________ State: __________________________ Zip: _________________

Insurance Co. Telephone: ____

Date of Injury or Accident: ____

Claim #: ____

Adjustor's Name (pip carrier): ___________________________Tel #:____________________________

Bodily Injury Insurance Carrier: ____

BI Insurance Co. Address: ____

City: _________________________ State:__________________________ Zip__________________

Attorney Information

Attorney Name: ____

Law Office Name: ____

Address: ____

City: _________________________ State: _________________________ Zip: __________________

Telephone: __________________________________ Fax:_________________________________

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Automobile Accident Injury Information:

Date:_______________

Patient Name:_________________________________ Patient Struck as a Pedestrian:______________

Date of Accident:______________________________ Time:____________________________ AM/PM

Pt. Speed was: Stopped Accelerating Slowing Constant Road Conditions:_________________

Pt. Vehicle:____________________________________ Other Vehicle:__________________________

Where was Vehicle Struck:______________________ Where Pt. was Sitting:____________________

Airbags Deployed: YES / NO Seat Break: YES / NO Aware prior to Impact: YES / NO
Seatbelt: YES / NO Brake On: YES / NO Head Restraint: YES / NO

Hand Position at Impact:________________________ Body Position at Impact:__________________
Head Position at Impact:________________________ Loss of Consciousness:___________________

Where did you go after the accident: ER / MD / DC / Work / Home If MD what kind:_____________
How did you get there: Self / Friend / Ambulance Time Missed from Work:__________________
Treatments Receive:____

Location of Accident:____
____

Police at Crash Site: YES / NO Police Report: YES / NO

Estimated Damage to Pt. Vehicle:________________ Other Vehicle:___________________________

Attorney:_______________________________________ Phone:__________________________________

Description of Accident:

____
____
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