NEW HOPE CHIROPRACTIC P.C.
SUNG D. KM D.C., C.A.
(Chiropractic & Certified Acupuncturist)
111 CHARLOTTE PLACE #301
ENGLEWOOD CLIFFS, NJ 07632
T: 201-227-8636 F: 201-227-8639

교통사고

DEMOGRAPHICS

Name (이름)_____ **Date of Birth (생년원일)**_____ **Sex (성별)** M/F

Social Security # _____ **Home Phone #** _____ **Cell Phone #** _____

Address (주소) _____ **City** _____ **State** _____ **Zip** _____

Occupation/Job (직장/회사) _____

Insurance Company (보험회사) _____ **Claim #** _____

Attorney Name (변호사) _____ **Phone #** _____

NATURE OF ACCIDENT

Date of Accident (사고날짜): _____

Place of Accident (사고장소): □ New Jersey (뉴져지) □ New York (뉴욕)

Were you: □ Driver (운전자) □ Passenger (보조석) □ In the front seat (앞쪽 의자)
□ In the rear seat (뒤쪽 의자) □ Pedestrian (보행자)

Number of people in your vehicle (차 안에 몇 명이 있었습니까): _____

Were you struck from (어디 쪽에서 부딪치셨나요): □ Behind (뒤쪽) □ Front (앞쪽)
□ Left Side (왼쪽) □ Right Side (오른쪽)

This accident is (어떤 사고인가요): □ Automobile(교통사고) □ Slip/Fall (낙상사고) □ Others

In your own words, please describe accident(사고에 대해 설명해주신다면): _____

_____

_____

I do certify that all statements on this form, to the best of my knowledge are true, accurate, and complete.

Signature (싸인) _____ **Date** (날짜) _____

HEALTH INFORMATION

What are your PRESENT complaints and symptoms? (지금 아픈 곳과 증상을 말씀해주세요?) _____

_____

_____

The condition is: □ Getting worse (나빠졌다) □ Improving (좋아지고있다) □ Same (똑같다)
(증상이:) □ Constant (계속있다) □ Comes and goes (있다없다)

The pain is: □ Stays in one spot (고정되어있다) □ Radiates/travels or shoots (움직인다)
(통증이:)

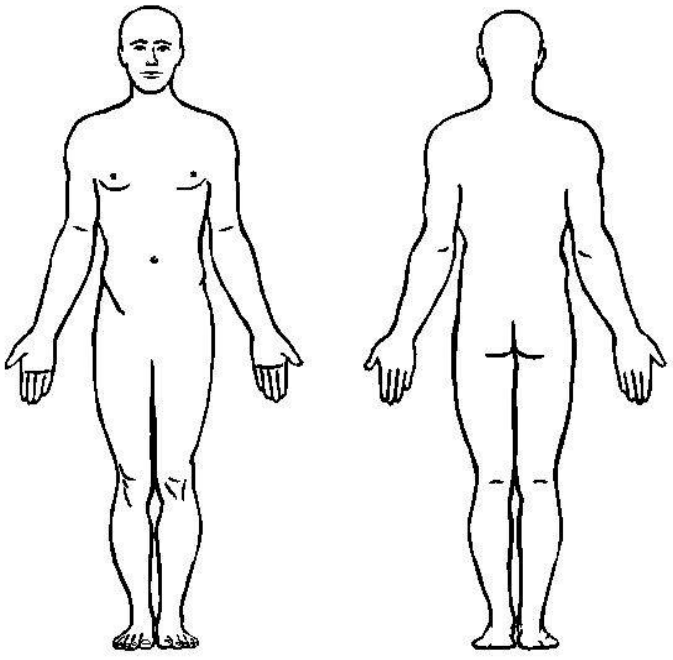
What makes this condition better/worse? Better(좋을때) _____ Worse (나쁠때)_____
(어땔때 증상이 좋아지나요/나빠지나요?)

Where were you taken after the accident? □ Emergency (응급실) □ Clinic (병원) □ Home (집)
(사고 후에 어디 가셨나요?)

Please describe any other illnesses or diseases? _____
(다른 질병이나 병을 가지고 계십니까?)

Have you ever been involved in an accident before? □ Yes □ No
(과거에 사고 나신적이 있으신가요?) **If YES, when** (언제): _____

Please mark the appropriate places with an "X" you now have or which you had problems with in the past.
(밑에 그림에 해당 증상에 "**X**"를 해주세요)
Please circle in the list below the places you have or which you had problems with in the past.
(행당 증상을 밑에 써있는 리스트에 동그라미를 해주세요)



Neck (목) **Jaw** (턱)

Middle Back (등) **Headache** (두통)

Lower Back (허리)

Shoulder (Which side?)_____
(어깨 – 어느쪽?)

Knee (Which side?)_____
(무릎 – 어느쪽?)

Ankle (Which side?)_____
(발목 – 어느쪽?)

Hip (Which side?)_____
(골반 – 어느쪽?)

Elbow (Which side?)_____
(팔꿈치 – 어느쪽?)

Wrist (Which side?)_____
(손목 – 어느쪽?)

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Patient: _____

Date of Accident: _____

Claim #: _____

Medical Provider's Name: Dr. Sung Dong Kim DC, CA

I authorize and request _____ insurance to pay directly to the above-named provider, the amount due me under terms of the above-referenced policy as a result of medical care rendered by that medical provider and all medical staff associated with the provider's office.

_____ _____

Patient's Signature or Parent/Legal Guardian **Date**

I have read the information sent by the Company concerning the Decision Point Review Plan, including any pre-certification requirements (collectively referred to hereafter as the "Plan") and, as a condition precedent to the Company's acceptance of this assignment, I agree for myself, and on behalf of all medical staff associated with my office, to the following:

1. I (we) have complied and will comply with all the procedures identified within the Plan
2. I (we) will comply with all requests for additional information from the Company concerning the presentation of the claim including but not limited to the submission of medical records with clinically supported findings to support the diagnosis, casual relationship to the accident and care plan and if necessary submit to Examinations Under Oath
3. I (we) will submit all disputes in accordance with the Internal Appeal Procedures set forth in the Plan
4. I (we) will not institute litigation or initiate the Personal Injury Protection Dispute Resolution process outlined in the Plan until there have been a final determination of the Internal Appeal Procedure of the dispute; and
5. In the event that I (we) fail to comply with the requirements of the Plan, and such failure results in the imposition of a co-payment penalty, I (we) will hold the patient harmless for such co-payment penalty insofar as I (we) will not seek payment from the patient for any unpaid portion of the medical services attributable to such failure to comply with the plan.

The Company does not provide coverage for any insured or pay benefits to any provider who has made fraudulent statements or engaged in fraudulent conduct or made any material misrepresentation in connection with either obtaining the policy or with any accident or loss for which coverage or benefits are sought.

I (we) understand that the Company has the right to reject this assignment of benefits.

_____ _____

Provider's Signature **Date**

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– DOCTOR'S LIEN –

To **ATTORNEY**: _____

_____

_____

PATIENT'S NAME: _____

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.

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 co protect said doctor. 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 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.

_____ _____

Patient's Signature or Parent/Legal Guardian **Date**

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may by necessary adequately to protect the said doctor named above.

_____ _____

Attorney's Signature **Date**

Attorney: Please date, sign, and return one copy to doctor's office at once.
Keep one copy for your records.