INSIGHT INSTITUTE OF NEUROSURGERY &NEUROSCIENCE (IINN)

JAWAD A. SHAH M.D. P.C. • INSIGHT PAIN MANAGEMENT CENTER • INTEGRATED HOSPITAL SPECIALISTS P.C.
INSIGHT IMAGING • INSIGHT RADIOLOGISTS P.C.
INSIGHT PHYSICAL THERAPY & NEURO-REHAB CENTER • INSIGHT CHIROPRACTIC CENTER

This information is needed to make sure that your bills are sent to the proper insurance. It is your responsibility to provide our office with correct information. If your information is incorrect or out-of-date, you may receive a bill. If you have any questions, please contact our Billing office.

Auto or Workman's Compensation Case *(Please circle)*

Patient Name:_____

Name of Insurance Company:_____

Name of Insurance Adjuster:_____

Phone number of Adjuster:_____

Address to send Claims:_____

_____

Claim Number:_____ Date of Injury or Accident:_____

For Auto Claims Only: *(Please Circle)*
Is your Medical Insurance Primary? Yes No
Is your claim in Litigation Yes No

If you have an Attorney involved:
Do we have permission to contact your attorney and/or share information regarding your medical care, including but not limited to: Progress notes and billing information pertaining to our facilities? Yes No _____ *(Initials)*

Law Firm Name:_____

Attorney's Name:_____

Phone Number:_____ Fax Number_____

Address:_____

_____

Signature: _____ **Date**:_____

For Office use Only:

Date verified/ Initials:_____ Date verified/ Initials:_____

Date verified/ Initials:_____ Date verified/ Initials:_____

Date verified/ Initials:_____ Date verified/ Initials:_____

Date verified/ Initials:_____ Date verified/ Initials:_____

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 ____/_____/_____ Any additional accidents? _____

Police Report: □ Yes □ No (If yes, please provide the office with a copy)

First Vehicle Type: □ Compact □ Mid-size □ Full-Size □ SUV □ Pick-up □ Motorcycle
How fast were you and/or the other vehicle traveling? _____
What side of your vehicle was hit? _____
Whose vehicle was it? Were you the driver or passenger? _____

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

Were you wearing a seatbelt? □ Yes □ No

Did your airbag deploy? □ Yes □ No

Accident Details
Accident Description
_____
_____
_____
_____
_____

What were your injuries?
_____
_____
_____
_____
_____

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

What hospital did you go to?

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 imaging taken? □ Yes □ No
If yes, what areas? _____
Did you have imaging taken prior to your accident? □ Yes □ No

Have you seen a doctor before the accident for similar symptoms? If yes, please explain the symptoms and what doctor.

_____
_____
_____

Patient Signature:_____ Date:_____

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4800 S. Saginaw St. • Ste. 1805
Flint, MI 48507-2669

Phone: (810) 275-9108
Fax: (810) 963-2881

RE: Lien against judgments/settlements

I, _____ , understand that I am personally responsible for all charges for services provided to me by the physicians and non-physicians of Jawad A. Shah M.D. PC and its associates, Insight Radiologists P.C. referred to as Insight Imaging, Insight Pain Management Center and Insight Physical Therapy & Rehab Center, hereby referred to as IINN. I instruct my attorney to withhold from any and all judgments or settlements monies owed to IINN prior to any distribution of any judgments or settlements to me or other debtors. Any monies owed should be paid directly to IINN. I further grant IINN a Lien against any judgments or settlements, for any and all services from the first date of service, throughout the pendency of my litigation. I further extend this Lien to any settlements or litigation proceeds, including third party actions for payments of services provided by IINN, even if all or part of these services may in theory be covered by a health insurance carrier. It is my understanding, that if at a later time IINN receives duplicate payment from a third party for these services, that IINN will refund the excess to me.

_____ _____

Date Patient Signature

I, _____ , attorney for the above named patient, agree to comply with the above instructions.

_____ _____

Date Attorney Signature

Date Received in office:___/___/_____