ARIZONA PAIN
WE CHANGE LIVES HERE

9787 N. 91st ST
Suite 101
Scottsdale, AZ 85258

Physician's Contract, Notice of Assignment and Authorization Form

Patient: _____ **Date:**_____

Patient's date of birth:_____ **Date of injury:**_____

Patient's attorney: _____ **Attorney's telephone #:**_____

I hereby authorize the medical staff of Arizona Pain (Physician) to furnish my attorney, the liability insurance company, or my health insurance carrier, a full report of all medical records and bills concerning the evaluation and treatment of myself in reference to my accident or potential legal action.

I authorize and direct my attorney and/or any insurance companies involved, to pay directly to Physician such sums as may be due and owed to the Physician for medical services rendered to me, both by reason of this incident and by reason of any other bills such as medical reports, conferences, depositions, and court appearances, that are due their office, and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect the Physician. Furthermore, I hereby assign to the Physician any and all proceeds of any settlement, judgment, or verdict which may be paid to my attorney or myself as a result of the injuries for which I have been treated or injuries in connection therewith to the extent of my indebtedness to the Physician. Furthermore, I agree that the Physician will have no liability for attorneys' fees and costs, and that there will be no reduction in the amount paid to Physician according to the common fund doctrine (sometimes referred to as the LaBombard decision).

I agree that regardless of the outcome of this legal case, I am fully and directly responsible to the Physician for the payment of the medical bills submitted by the Physician and for the full amount of the bill for services rendered to me. This agreement is made solely for the Physician's additional protection and in consideration of their awaiting payment. Also, I understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I also agree to waive the defense of the statute of limitations in the event it is necessary for a legal claim to be filed against me for this unpaid bill if the bill remains outstanding beyond the statute.

In the event that any party to this contract and assignment commences legal proceedings against the other to enforce the terms hereof, or to declare rights hereunder as the result of any breach of any covenant or condition of this contract and assignment, the prevailing party in any such proceeding shall be entitled to recover from the losing part its cost of suit, including reasonable attorney's fees, as may be fixed by the court. I hereby agree and instruct that in the event another Attorney is substituted in this matter, the new Attorney will honor this contract and assignment as inherent to the settlement and enforceable upon the case as if it were executed by the new Attorney.

Patient:

l fully understand that if I belong to a health organization (such as an HMO or FPO) l expressly agree that the Physician may bill and collect the full amount of the billed charges for medical services provided and is not limited by the amount of fees as may be paid by those organizations. I specifically acknowledge and agree that the Physician may bill and collect the full billed fees from any and all sources of payments involved in this case, including defendants, health insurance, med pay coverage and legal settlements, if any. Finally, I agree and understand that if my health insurance is billed for medical services related to my accident, the Physician are not obligated to accept any contractual allowances and make contractual adjustments to the total bill, and that l, the patient, am personally and fully responsible for payment of the remaining balance.

I have been advised that if my Attorney does not wish to cooperate in protecting the Physician’s interest as outlined in this Agreement, then the Physician will not await payment but will require me to make payments on a current basis.

Date:_____ Patient's Signature:_____

Attorney's Acknowledgment

The undersigned, being the attorney of record for the above patient, does hereby agree to observe and comply with all the terms of this document and agrees to withhold such sums for any settlement, judgment, or verdict as may be necessary to adequately protect said Physician named above. The attorney also agrees to advise the Physician within 10 days of notice of any change of the conditions of this case that may jeopardize payment of the bill to the Physician. Furthermore, I agree that the Physician will have no liability for attorneys' fees and costs, and that there will be no reduction in the amount paid to the Physician according to the common fund doctrine (sometimes referred to as the LaBombard decision).

Date:_____ Attorney's Signature:_____

Motor Vehicle Accident Assessment Form

ARIZONA PAIN
WE CHANGE LIVES HERE

Your name:_____ Today's date:_____

Location of accident:_____ Date of accident:_____

Where were you sitting?

☐ Driver seat ☐ Front Right

☐ Rear Left ☐ Rear Right

Where was your car hit?

☐ Rear-end ☐ Front-end

☐ T-Bone ☐ Other_____

On which side was your car hit?

☐ Left-side ☐ Right-side

☐ Other_____

Did you lose consciousness? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No

Have any X-rays/CT scans/MRIs been taken? ☐ Yes ☐ No

Your car's speed: _____(mph)

Other car's speed:_____(mph)

Did the airbag deploy? ☐Yes ☐ No

Was there a police report filed and who was at fault?_____

What symptoms did you have after the accident?_____

What was your treatment **on the day** of theaccident/injury?_____

What has been your treatment **since** theaccident/injury?_____

Which doctors have you seen regarding thisaccident/injury?_____

What symptoms are you experiencing now from the accident? (Start with the worst complaint) _____

_____

_____

Have they gotten better or worse since the accident?_____

Did any of your present symptoms exist before the accident? ☐ Yes ☐ No (please describe)_____

_____

If Yes, how or are the symptoms different?_____

Do you think that these symptoms are directly related to the accident?_____

Have you received other treatments for these same areas in the past? ☐Yes ☐No

If so, what were the treatments?_____

_____

_____

Automobile Insurance/Attorney Information

Please provide us with information about automobile insurance coverage (yours and the party that injured you) and attorney. Please provide the staff with a copy of your automobile insurance card if you are using this insurance.

Have you hired an attorney for this case? ☐ Yes ☐ No

If yes, please provide attorney name & telephone # _____

My case is: ☐ currently in litigation ☐ closed and no longer in litigation ☐ Other _____

I have a copy of the police report concerning this accident: ☐ Yes ☐ No

Med Pay Information (your auto insurance coverage)

Insured: _____

Insurance Co. _____

Agent: _____

Agent Tel. #: _____

Policy #: _____

Med pay $ amount: _____

Liability Information (at fault party's coverage)

Insured: _____

Insurance Co. _____

Agent: _____

Agent Tel. #: _____

Claim #: _____

Have you filed a claim? ☐ Yes ☐ No

Form reviewed by:		Received and logged by billing department:	
_____	_____	_____	_____
Signature of Lien Department	Date	Date	Signature of biller