



DR. LAURA E. HARRINGTON
Liverpool Chiropractic & Wellness, PLLC

403 Tulip Street
Liverpool, New York 13088
Telephone: (315) 461-4510

Client Name _____

Date _____

Vehicle Accident Information

Date of Accident _____ Time of Accident _____ a.m. p.m. a.m.

Please describe the accident in your own words: _____

Were you the: Driver Front Passenger Rear Passenger Pedestrian

How many people were in the accident vehicle? _____

Accident Site

Road/Street Name _____
City/State _____
Nearest intersection _____
Driving conditions Dry Wet
 Icy Other _____

Vehicle Information

Make and model of vehicle you were in _____

Were you wearing a seatbelt Yes No
If yes, what type? Lap Shoulder
Was the vehicle equipped w/ airbags? Yes
If yes, did it/they inflate properly? Yes No
Did your seat have a headrest? Yes No
If yes, what was the position of the headrest?
 Low Midposition High
Direction you were headed? _____
Speed you were traveling? _____

Other Vehicle Information (If applicable)

Make and model of other vehicle _____

Direction other vehicle was headed? _____
Speed other vehicle was traveling? _____

Impact

Did your car impact another vehicle? Yes No
Did your car impact a structure? Yes No
If yes, explain _____
Did any part of your body strike anything in the vehicle? Yes No
If yes, explain _____
Was impact from:
 Front Rear Left Right Other
At the time of impact were you:
 Looking straight ahead Looking to the left
 Looking to the right Looking up
 No Looking down
Were both hands on the steering wheel? Yes No
If no, which hand was on the wheel? Right Left
Was your foot on the brake? Yes No
Were you: Surprised by impact Braced for impact
Did you go to the hospital? Yes No
If yes, which hospital? _____

Police

Did the police come to the accident site? Yes No
Were there any witnesses? Yes No
Was a police report filed? Yes No
Was a traffic violation issued? Yes No
If yes, to whom? _____

Client Name _____

Date _____

Vehicle Insurance Information

Name of Vehicle Owner _____

Vehicle Owner's Address _____

Insurance Company _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Insurance Company Phone _____ Agent's Name _____

Claim # _____ Policy # _____

Legal Representation

Have you retained an attorney? No Yes

If yes, Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

I authorize release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all my insurance submissions.

X _____

Signature of client or parent if minor

Date

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM**

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, ("Assignor") hereby assign to Dr. Laura E. Harrington, D.C., ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, not withstanding any other agreement
(Print accident date)
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

(Print name of Patient)

(Signature of Patient)

(Date of signature)

(Address of Patient)

Dr. Laura E. Harrington, D.C.
(Print name of Provider)

(Signature of Provider)

403 Tulip Street

(Date of signature)

Liverpool, NY 13088
(Address of Provider)