Howard J. Rudnick, M.D.
General Orthopaedics and Rehabilitation

4600 Linton Boulevard, Suite 250
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ACCIDENT FORM

Patient's Name: _____ Age: _____ Date of Birth: _____-_____-_____

ACCIDENT INFORMATION

Date of Accident: _____ Occupation: _____

Did this injury happen while working? ☐ YES ☐ NO

Does this injury relate to an auto accident? ☐ YES ☐ NO

Is this injury related to a pending lawsuit? ☐ YES ☐ NO

Briefly describe your accident: _____

_____

Were you admitted to the hospital ☐ YES ☐ NO Did you lose consciousness? ☐ YES ☐ NO

If yes, Date of Admission: _____-_____-_____ Date of Discharge: _____-_____-_____

What hospital or emergency clinic where you taken to, if any? _____

Were you taken to the hospital or emergency clinic by an ambulance? ☐ YES ☐ NO

Briefly list areas of present pain, numbness, or weakness: _____

_____

_____

Describe the treatment you have received for this accident?

_____

_____

Please list ALL treating physicians in regards to this accident (i.e. Chiropractic Physicians, Pain Management, Internist, Surgeons, etc...)

Doctor's Name: _____ Specialty: _____ Treatment: _____

Doctor's Name: _____ Specialty: _____ Treatment: _____

Doctor's Name: _____ Specialty: _____ Treatment: _____

MOTOR VEHICLE ACCIDENTS (ONLY)

Type of vehicle you were in? _____ Did police come to the scene? ☐ YES ☐ NO

Approximate vehicle dollar amount of damage? $_____ Dominant hand? ☐ LT ☐ RT

Were you wearing a seat belt? ☐ YES ☐ NO Did the air bags deploy? ☐ YES ☐ NO

Were you cited for the accident? ☐ YES ☐ NO

Patient position in the vehicle during the accident? ☐ DRIVER ☐ FRONT PASSENGER ☐ BACK SEAT

If another vehicle was involved, what type of vehicle was it: _____

Did you strike your head or other body part on impact? Please explain _____

_____

_____

Please list any old injuries not related to this auto accident? _____

_____

_____

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AUTHORIZATION, ACCEPTANCE, AND ACKNOWLEDGMENT FOR PROTECTION OF PAYMENT

I hereby authorize and instruct my attorney whose signature appears below to pay to the physician members of Howard J. Rudnick, M.D., PLLC all of the charges for services rendered by the physician and/or staff of said medical center whatsoever or any balance thereof for medical treatment, in hospital or out-patient care, for reports made, deposition given, and time spent as an expert witness in this matter. Said payments shall be made from my monies received by said attorney as a result of any compromise or settlement or by way of collection of any judgment relating to my claim for injuries for which the staff of Howard J. Rudnick, M.D., PLLC has rendered services.

I hereby authorize Howard J. Rudnick, M.D., PLLC to furnish, upon request, to my attorney whose signature appears below, copies of medical records pertaining, but necessarily limited to my condition from injuries sustained on or about the _____ day of _____, 20_____. It is agreed that nothing herein relieves me of the primary responsibility and obligation of paying my medical bills from Howard J. Rudnick, M.D., PLLC for all services rendered. I also understand that if a favorable legal settlement does not occur, I remain personally liable for payment of the total bill for services rendered by Howard J. Rudnick, M.D., PLLC. If I have insurance that will cover this bill, I will obtain proper forms and assist the medical office in obtaining payment for the services from these insurance carriers.

In the event of any dispute as to the charge for services rendered, I hereby authorize and direct my attorney to withhold the full sum claimed by Howard J. Rudnick, M.D., PLLC until such time as the matter is settled by compromise, settlement, judgment, or dismissal. In the event that the medical facility prevails, I shall be responsible for all costs of collection incurred by Howard J. Rudnick, M.D., PLLC, including a reasonable attorney's fee. Additionally, I hereby agree to waive the defense of the Statute of Limitations. In the event that a claim is filed against me by reason of any unpaid bills, I will not raise the defense of the Statute of Limitations. I also agree to the terms of the assignment below.

_____ _____

Patient or Legal Guardian Name (Print) **Witness Signature**

_____ _____

Patient or Legal Guardian Signature: **Date**

ATTORNEY AUTHORIZATION, ACCEPTANCE, AND ACKNOWLEDGMENT FOR PROTECTION OF PAYMENT

I, the undersigned attorney for the patient referred to above, agree to fully comply with the foregoing Authorization, Acceptance, and Acknowledgment for Protection of Payment.
Further, I accept the terms of the above authorization and in consideration of the doctor's agreement to render such medical reports and/or testify and/or be deposed, I shall agree to be personally responsible for any charges relating to medical reports, deposition fees, or expert witness fees. Further, I agree to withhold sufficient funds to pay all sums claimed by Howard J. Rudnick, M.D., PLLC in full for any services or charges rendered or made until said medical provider consents to the final disposition of the same. I further agree that in the event funds of the patient do not come into my possession then, I will personally be responsible for charges for medical reports, deposition fees, and expert witness fees of the physician members of the referred to medical facility and agree to make full payment within thirty (30) days of disposition of the matter by judgment, settlement, or dismissal. In the event that this case is transferred to another attorney, I acknowledge that Howard J. Rudnick, M.D., PLLC must be notified in writing, otherwise the obligation of the authorization rest with me.

_____ _____

Patient or Legal Guardian Name (Print) **Date**

_____ _____

Attorney's Name **Phone Number**

_____ _____

Attorney's Signature **Attorney's Address**