Instructions for completing Motor Vehicle Accident Forms:

Premier Family Physicians wants to assist you with your financial concerns regarding payment for services provided you for injuries you that you have sustained in an automobile accident.

If a motor vehicle insurance company is involved, we will file your claims to your health insurance, only as a precaution that the other insurances indicated below delay, deny or reduce your medical payments. Your health insurance is not considered primary in automobile accidents, and is subject to subrogation -and/or may not pay your automobile related claims if other insurances are responsible for your injuries. Therefore, in order to assist you in filing all claims applicable to your auto accident please provide the following:

MEDICAL COVERAGE ON VEHICLE YOU OCCUPIED (PIP or Med-Pay)
A report of bodily injury must be made to this insurance-
In order to file a claim we must have the following information:
A CLAIM NUMBER AND ADJUSTER WILL BE ASSIGNED-
IT MAY BE DIFFERENT THAN YOUR PROPERTY DAMAGE ADJUSTER
The adjuster will forward you an application of benefits. The claims will not be considered without completion of this form. Please complete the forms so that our submitted claims will be considered for payment.

OTHER PARTY/AT FAULT INSURANCE:
A report of bodily injury must be made to this insurance
A CLAIM NUMBER AND ADJUSTER WILL BE ASSIGNED
IT MAY BE DIFFERENT THAN YOUR PROPERTY DAMAGE ADJUSTER
PLEASE CONFIRM THAT LIABILITY HAS BEEN ACCEPTED FOR THIS CLAIM.

We will need all medical billing information in order to file a medical claim.
Claim #s
Adjustors and their
Billing address/Fax number

Please be advised that you, the patient, are financially responsible for all charges for the medical services rendered.

PLEASE CONTACT US IF YOU WILL BE SEEKING ATTORNEY REPRESENTATION. THERE ARE A SELECT FEW ATTORNEYS THAT OUR OFFICE CHOOSES NOT TO ACCEPT AS A GUARANTEE OF PAYMENT.

I have read and understand the financial policy.

Signature_____ Date_____

FAQs

What is an assignment of benefits?
The assignment of benefits allows your insurance to pay us directly so you are not billed.

Why should I file on my motor vehicle insurance if the accident was not my fault?
The medical coverage on your auto policy-Personal Injury Protection(pip) or medpay- is to help you receive immediate medical treatment regardless of who's determined to be at fault. Your insurance premiums should not increase if the accident was not your fault, and may if it is determined that you are at fault

What if the person at fault does not have insurance?
Please check your policy for uninsured or under insured medical coverage. There is usually additional coverage for this issue on most policies in Texas.

If the person at fault fails to provide their insurance coverage, there may be other means to obtaining the information. The officer at the scene will obtain that information at some point, you may contact the police department once the police report has been filed. If a citation was issued at the time of the accident, the person may present valid insurance at a court of law to avoid fines, or you may contact that person and obtain this information to avoid a civil suit being filed.

Why do you want to file my health insurance? What does subrogation mean?
We will file to your current health insurance so that if your auto claim is denied, you still have some form of coverage for your medical bills.
Subrogation means that if your health insurance and the auto insurance plans pay for your claim, your health insurance plan will request the money refunded back to them, since they are not the primary responsible payer. This is part of the settlement process. We do not keep any overpayments/credits.

What is a third party motor vehicle liability claim? What is covered under a third party liability bodily injury claim?
If a person is found at fault in a collision and injuries are sustained, this is considered a bodily injury liability claim. Liability claim is the party found at fault in the collision.
A bodlily injury claim includes all reasonable and customary medical bills related to the accident, off time benefits, travel expenses and a settlement for any future medical service that may be recommended by the doctor, and compensation for pain and suffering up to the benefit maximums set by policy limits.

What is covered under a third party liability bodily injury claim?
A bodily injury claim includes all medical charges reasonable and related to the accident, off time benefits, travel expenses, a settlement for any future medical recommended, and also compensation for pain and suffering up to the benefit maximums set by policy limits.

Why would I need to seek legal counsel regarding an automobile accident?
Some of the reasons you may want to seek legal counsel are to protect and obtain benefits that may be denied based on an adjusters decision to deny payment for your vehicle repair or medical charges for severity of injury—deny that you were injured, deny the severity of injuries, or simply deny any liability for the claim. In most cases, our office is able to negotiate with your adjusters for medical charges. However, if the claim is denied entirely then you may have no

alternative but to seek legal counsel.

How do I guarantee that my providers are paid for services rendered to avoid being billed directly?
Please check with all your medical providers prior to signing a settlement or prearranged settlement agreement and verify that payment has been received. Once you sign a settlement agreement with the insurance company to settle your claim, all providers that are not included in your settlement will not get paid. You will be responsible for all charges.

How will I know when to settle my claim?
You will know when to start the negotiation process to settle your claim once you and your doctor have determined that you have reached pre-accident condition, or when your doctor has indicated that you are at maximum medical improvement. This will mean that a final evaluation, reports, records and billing will be forwarded to the insurance company. If the insurance company does not want to pay any portion of your claims for any reason, please contact our office for additional clarification and documentation.

What do I do when I don't know what to do?
Please contact our billing office at 512-892-7076 and talk with your personal case manager to assist you in with this process or ask any questions that you may have. Your provider wants to eliminate these concerns and assure you that we are able to help you regarding your financial obligations.

Intake Form MVA

Premier Family Physicians

Patient Name: _____

To help us provide the best care possible, please thoroughly complete and sign the following pages. This information is confidential and will be kept as a part of your permanent record. None of this information will be shared outside this office, unless it is authorized by the patient.

General Information

Patient Name: _____ Date of Birth: ___/___/_____
(last) (first)

SS#: _____ Age: _____ Sex: Male / Female*

Address: _____
(street) (city) (state) (zipcode)

Home Phone: _____ Cell: _____

Work Phone: _____ Email: _____

Occupation: _____ Employer: _____

Primary Care Physician: _____ Location: _____ Phone: _____

*Female Only

Are you pregnant? yes / no Due date: ___/___/_____ OBGYN: _____

Are you a Medicare patient? yes / no Medicare #: _____

Emergency contact: _____
(name) (phone) (relationship)

Consent to Examination

Proper evaluation of your current condition includes the appropriate history and physical examination. By signing below you attest that the information above is true and correct and also, you *give permission for the doctor and the staff to conduct necessary evaluation*, including any physical testing required.

Printed Patient Name: _____ Date: ___/___/_____

Patient Signature: _____ Date: ___/___/_____

If the patient is a minor

Printed name of Parent/Guardian: _____ Date: ___/___/_____

Signature of Parent/Guardian: _____ Date: ___/___/_____

Intake Form MVA

Premier Family Physicians

Patient Name: _____

Insurance Coverage

Primary Medical Insurance (Please present your insurance card when returning this form)

Insurance Carrier: _____ Phone: _____

Policy Holder Name: _____ _____

Policy Holder's Date of Birth: ___/___/_____ Relationship to Patient: _____

Policy #: _____ Group #: _____

(If you are seeking treatment because of an accident/ injury sustained while on the job, please complete this section.)

Workers Compensation Injury

Employer: _____ Phone: _____

Address: _____

(street) (city) (state) (zipcode)

Did you file an accident/injury report? yes / no Date of Report: ___/___/_____

Date of accident/injury: ___/___/_____ Time: _____

Workers Compensation Carrier: _____ Name of Adjuster: _____

Phone: _____ Claim #: _____

(If you are seeking treatment as a result of an auto accident, please complete this section.)

Auto Accident/Insurance Date of Accident: ___/__/_____

Patient Information (Vehicle you were in)

Auto Insurance Carrier: _____ Phone: _____

Name of Adjuster: _____ Claim #: _____

Involved Party Information (Other Auto Involved)

Name: _____ Phone: _____

Auto Insurance Carrier: _____ Phone: _____

Name of Adjuster: _____ Claim #: _____

Attorney Name and Number:_____

Assignment of Benefits

I hereby assign and grant the benefits that I am eligible to receive for professional services rendered in this office. I authorize the release of any medical information necessary to process any insurance claims for payment. I understand that I am financially responsible for those charges not paid by my insurance.

Printed Patient Name: _____ Date: ___/___/_____

Patient Signature: _____ Date: ___/___/_____

Intake Form MVA

Premier Family Physicians

Patient Name: _____

Personal Health History

An accurate clinical picture of your current state of health is needed. Please check the frequency of all conditions you are currently experiencing or that have changed since the accident.

Key: O = Occasional F = Frequent C = Constant

General
O F C
[ ] [ ] [ ] Dizziness
[ ] [ ] [ ] Fainting
[ ] [ ] [ ] Fatigue
[ ] [ ] [ ] Fever
[ ] [ ] [ ] Headache
[ ] [ ] [ ] Neuralgia
[ ] [ ] [ ] Night Sweats
[ ] [ ] [ ] Poor Posture
[ ] [ ] [ ] Sciatica
[ ] [ ] [ ] Sweats
[ ] [ ] [ ] Involuntary Shaking
[ ] [ ] [ ] Unexplained weight loss
[ ] [ ] [ ] Fibromyalgia
[ ] [ ] [ ] Poor diet

Gastrointestinal
O F C
[ ] [ ] [ ] Belching/Gas
[ ] [ ] [ ] Bloating
[ ] [ ] [ ] Colitis
[ ] [ ] [ ] Constipation
[ ] [ ] [ ] Diarrhea
[ ] [ ] [ ] Poor appetite
[ ] [ ] [ ] Nausea
[ ] [ ] [ ] Vomiting

Muscle/Joint
O F C
[ ] [ ] [ ] Arthritis
[ ] [ ] [ ] Muscle weakness
[ ] [ ] [ ] Neck stiffness
[ ] [ ] [ ] Low back pain
[ ] [ ] [ ] Back stiffness
[ ] [ ] [ ] Mid back pain
[ ] [ ] [ ] Joint locking
[ ] [ ] [ ] Painful clicking
[ ] [ ] [ ] Muscle spasm
[ ] [ ] [ ] Neck pain
[ ] [ ] [ ] Muscle tremors
[ ] [ ] [ ] Bone fracture

Pain/Numbness
O F C
[ ] [ ] [ ] Shoulders
[ ] [ ] [ ] Arms
[ ] [ ] [ ] Elbows
[ ] [ ] [ ] Hands
[ ] [ ] [ ] Hips
[ ] [ ] [ ] Legs
[ ] [ ] [ ] Knees
[ ] [ ] [ ] Ankles
[ ] [ ] [ ] Feet
[ ] [ ] [ ] Heels
[ ] [ ] [ ] Back
[ ] [ ] [ ] Groin

Genitourinary
O F C
[ ] [ ] [ ] Blood in urine
[ ] [ ] [ ] Frequent urination
[ ] [ ] [ ] Incontinence
[ ] [ ] [ ] Kidney infections
[ ] [ ] [ ] Kidney stones
[ ] [ ] [ ] Painful urination
[ ] [ ] [ ] Difficulty urinating

Respiratory
O F C
[ ] [ ] [ ] Chest pain
[ ] [ ] [ ] Chronic cough
[ ] [ ] [ ] Difficulty breathing
[ ] [ ] [ ] Wheezing

Ear, Eye, Nose, Throat
O F C
[ ] [ ] [ ] Asthma
[ ] [ ] [ ] Colds
[ ] [ ] [ ] Ear ache
[ ] [ ] [ ] Ear discharge
[ ] [ ] [ ] Ear infections
[ ] [ ] [ ] Enlarged glands
[ ] [ ] [ ] Eye pain
[ ] [ ] [ ] Hoarseness
[ ] [ ] [ ] Hearing Loss
[ ] [ ] [ ] Sinus Infections

Cardiovascular
O F C
[ ] [ ] [ ] Ankle swelling
[ ] [ ] [ ] Heart attack
[ ] [ ] [ ] High blood pressure
[ ] [ ] [ ] Low blood pressure
[ ] [ ] [ ] Poor circulation
[ ] [ ] [ ] Rapid heartbeat
[ ] [ ] [ ] Slow heartbeat

Conditions
Have/had
[ ] Addiction
[ ] Anemia
[ ] Back surgery
[ ] Cancer
[ ] Diabetes
[ ] Eating disorder
[ ] Eczema
[ ] Epilepsy
[ ] Gout
[ ] Heart disease
[ ] HIV/AIDS
[ ] Multiple Sclerosis
[ ] Pacemaker
[ ] Stroke
[ ] STD
[ ] Hepatitis

Any other current health issues not covered above: _____

_____

Please list any medications/drugs you are currently taking:_____

_____

Patient Name:_____ Date:___/___/____

Patient Signature:_____ Date:___/___/____

Intake Form MVA

Premier Family Physicians

Patient Name: _____

Primary Complaints

What is/are your main complaint(s) related to you motor vehicle accident? (check those that apply)

[ ] Dizziness/Vertigo	[ ] Elbow Pain	[ ] Limited Range of Motion	[ ] Pins and Needles
[ ] Headaches	[ ] Digestive Problems	[ ] Fatigue	[ ] Vision Disturbances
[ ] Sciatica	[ ] Asthma	[ ] Hip Pain	[ ] Clicking and Grinding
[ ] Low Back Pain	[ ] Low Back Stiffness	[ ] Chest Pain	[ ] Ear Discomfort/Pain
[ ] Mid/Upper Back Pain	[ ] Shoulder Pain	[ ] Shoulder Stiffness	[ ] Tension
[ ] Neck Pain	[ ] Neck Stiffness	[ ] Depression	[ ] Numbness
[ ] Wrist/Hand Pain	[ ] Knee Pain	[ ] Nerve Pain	[ ] Ankle/Foot Pain
[ ] Difficulty Breathing	[ ] Jaw Pain/Stiffness	[ ] Difficulty Sleeping	[ ] Weakness

Other (not covered above): _____

When did the condition begin? _____

What do you think caused it? _____

Is this condition interfering with your:

work / sleep / daily routine / other: _____

Is this condition a work-related accident/incident?

yes / no

If yes, did you report it? yes / no

Is this condition a result of a motor vehicle accident?

yes/ no

If yes, the date of the accident: ___/___/____

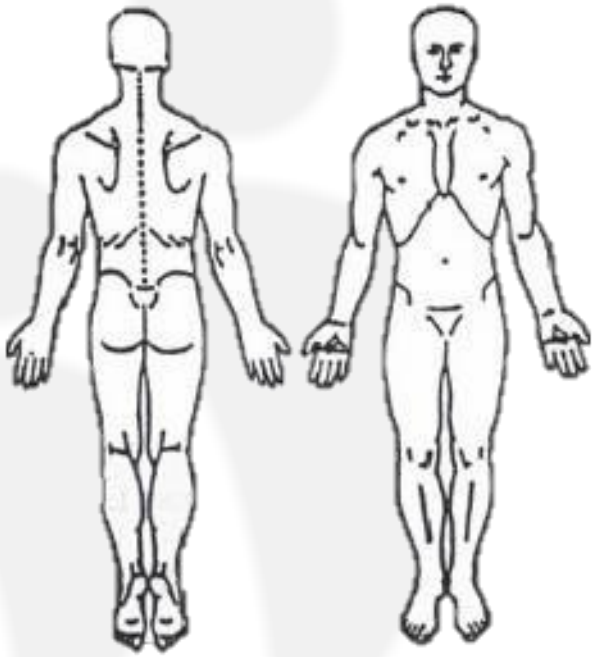
What positions/activities make it feel *worse:*

_____

What positions/activities make it feel *better:*

_____

Please indicate area(s) of pain below



What have you tried that has *not* worked to alleviate your condition(s)? _____

_____

Have you received treatment for *this* condition by other doctors/therapists? yes / no

If so, by whom and when? _____

Have you had similar conditions in the past? yes / no How long ago? _____

Since it began, is this condition generally getting: worse / better / stays the same

Printed Patient Name: _____ Date: ___/___/_____

Patient Signature: _____ Date: ___/___/_____

IRREVOCABLE ASSIGNMENT AND CONVEYANCE OF LIEN INTEREST IN INSURANCE PROCEEDS, GRANT OF POWER OF ATTORNEY AND PAYMENT AGREEMENT

THIS IRREVOCABLE, NON-RESCINDABLE, ASSIGNMENT AND CONVEYANCE OF LIEN INTEREST IN INSURANCE PROCEEDS is entered this date by and between the undersigned Health Care Recipient, hereinafter called "Patient", and South Austin Family Practice Clinic, LLP., d/b/a Premier Family Physicians, 5625 Eiger Rd., Suite 200, Austin, Texas 78735 hereinafter called "Provider".

WHEREAS, Patient desires to receive health care services from Provider and requests that Provider provide such services, but defer payment on the part of Patient for such services until Patient secures his/her insurance settlement proceeds. In consideration of Provider's willingness to agree to such terms and in accordance with the provisions of Tex. Ins. Code, Title 8, Subtitle A, Chapter 1204, §1204.053(a) [entitled "Assignment of Benefits"], Patient does hereby: (i) waive any obligation on the part of the Provider under Tex. Civ. Pract. & Rem. Code Ann., §146.002(b), and {ii) irrevocably assign and convey the following lien interests, rights and benefits to Provider as the legal consideration and inducement to cause Provider to forego its legal right to require payment upon provision of services and wait for the payment of such benefits from Patient or Patient's representative. It is hereby agreed:

SECTION 1. Patient hereby irrevocably acknowledges full financial responsibility for all services provided to patient by Provider as consideration for such Provider services. Patient irrevocably assigns and conveys a lien interest to Provider in all benefits to which Patient has, may have, or may maintain a legal entitlement to receive in the form of future monetary proceeds due to be paid by or from any liability or health insurance plan{s), including PIP statutory insurance benefits, that are maintained by Patient or under which Patient derives some legal entitlement, as consideration for all health care services provided by Provider to Patent, up to the total amount of all unpaid charges for such Provider services. Patient irrevocably conveys and assigns to Provider such lien interest lien on any proceeds he/she is entitled to receive from any insurer, including his/her PIP insurance benefits up to the dollar amount of any unpaid charges owed by Patient to Provider. Such conveyance of lien interest shall be deemed hereunder to apply to: (i) any and all benefits, claims and/or monetary proceeds to which Patient may be or become entitled to receive, payable by or from any automobile medical or PIP insurance coverage maintained by Patient or any person under whose policy of insurance Patient may have a lawful right of recovery, (ii) any and all benefits, claims and/or monetary proceeds to which Patient may be or become entitled to receive, payable by or under any third party liability insurance coverage as a result of any claim for damages to which Patient may have a right of recovery, and (iii) a "common law lien interest" in, and all contractual rights and claims to, any and all insurance proceeds to which Patient has or maintains a legal entitlement, to be paid by or from any insurance company, health care benefit plan, or any other party contractually liable for payment of all or any portion of the charges for health care services rendered by Provider to the Patient as a result o'·1e injuries sustained by Patient. This irrevocable conveyance and assignment of lien interest and conveyance and assignment of contractual rights to and for those charges attributable to Provider's health care services shall extend to, but not be limited to, Provider's entitlement to any and all claims to insurance proceeds payable as a result of any insurance coverage for damages borne by the Patient which has given rise to the above referenced health care services provider by Provider.

This irrevocable assignment and conveyance of lien interest shall extend to the total amount of charges incurred by Patient for those services rendered by Provider. Patient agrees that full payment for all services rendered by Provider is due upon receipt of said services and Patient accepts full financial responsibility for payment for such services. Patient acknowledges that Patient is ultimately financially responsible for the payment of all services that Patient receives from Provider regardless whether any portion of those fees and charges due to be paid by Patient to Provider are paid through insurance proceeds to which Patient has asserted a claim. Patient acknowledges that Provider's acceptance of Patient's irrevocable assignment of benefits and lien interest is a convenience to Patient, and that Provider may revoke this assignment and lien interest at any time.

SECTION 2. Patient hereby grants and conveys Provider this irrevocable lien interest against any and all monetary proceeds to which Patient may or have a legal claim against the party or parties that gave rise to Patient's claims for damages for which Provider has been engaged to provide healthcare services and any entitlement to insurance and/or health care payment proceeds due to be paid to Patient as a result of any claim Patient has or may have against any party whose negligence may have caused Patient's injuries or illnesses for which Patient has asserted Patient's pending insurance claim. Patient hereby grants this irrevocable lien interest against all such insurance or health care proceeds to which Patient is, or may become, entitled, including, but not limited to, all proceeds due to be paid on Patient's behalf out of any Medical Payment or statutory Personal Injury Protection insurance coverage, as a result of those services rendered to Patient by Provider. Said lien interests shat '.10t exceed the total amount of expenses and debt obligations incurred, and due to be paid, by Patient to Provider for such services rendered.

Date

Patient Signature

SECTION 3. Patient hereby irrevocably directs all insurers, health care plans, legal counsel, and other persoit.' or parties responsible for the payment, co-payment or other obligation for Patient's health care costs arising from injuries sustained by Patient for which the above referenced services have been provided by Provider, to remit and/or make all monetary payments remitted as consideration, in whole or in part, for those health care services rendered by Provider for and on behalf of Patient, directly to Provider. Patient further directs that any lawyer or representative employed by Patient to represent Patient in any action for which the above referenced services have been rendered by Provider, insurer or third party, shall be, and is hereby, irrevocably instructed and required to withhold from any monetary distribution to Patient, Patient's lawyer and/or any other person or party asserting any monetary interest against any proceeds to which Patient may awarded, the full amount of Patient's outstanding and unpaid account due and owing to Provider out of any private party settlement proceeds, insurance settlement proceeds of whatever nature (liability, PIP, etc.), and /or any court verdict and remit payment of the dollar amount of Patient's unpaid and outstanding account with Provider, directly to Provider immediately upon receipt of same. This directive made by the

- Patient to the Patient's lawyer is to be deemed irrevocable and non-rescindable and shall extend to and include any PIP or medical payment benefits recovered by or on the Patient's behalf of the Patient or Patient's lawyer.

SECTION 4. Patient willfully and voluntarily makes and appoints Provider, through its duly appointed representative of the City of Austin, Travis County, Texas, as Patient's lawful Attorney-in-Fact for purposes of receiving and directing disbursement of those payments of insurance or settlement proceeds to be paid to Patient, or on Patient's behalf, as compensation for those for the health care services rendered by Provider, and the resultant payment obligations owed by Patient to Provider as a result of same. Patient hereby delegates and conveys to Provider those rights and powers of substitution on Patient's behalf, to ask, demand, sue for, collect, endorse, sign, and receive such monetary proceeds, in Patient's name, to PIP insurance, other health benefits, and third party claims relating to services rendered to Patient by Provider. Although Provider is granted such special powers contained herein, Provider is not obligated or compelled to exercise such powers but may do so at Provider's discretion. Patient agrees to cooperate with Provider to request and receive from any insurer, employer, or other third party payor any and all information or supporting documentation concerning or touching upon the handling, calculation, processing, or payment of any claims arising from services rendered to Patient by Provider.

SECTION 5. To the extent that Patient has lawful authority, Patient waives any applicable statute of limitations that may at any time interfere with Provider's right to collect for services rendered to Patient. Patient agrees that in the event Patient or Patient's authorized representative, including legal counsel, receives any check, draft, or other payment subject to this Agreement, Patient and Patient's authorized representative shall be deemed to serve in a fiduciary capacity to Provider, for the benefit of Provider, with full obligation to immediately deliver said check(s), draft(s), or payment(s) to Provider. Provider agrees to apply the proceeds from said check(s), draft(s), or payment(s) to Patient's debt for services rendered.

SECTION 6. Patient hereby irrevocable consents to, and authorizes, his lawyer/legal counsel to release to Provider, upon request by Provider, any and all records or documentation pertaining to Provider's insurance claims, legal claims, pending causes of action, or otherwise pertaining to the expense or charge for any service rendered by Provider for Patient's benefit.

SECTION 7. Patient irrevocably agrees and consents to Provider's submission of a copy of this Agreement and any other claim for payment of insurance proceeds to any and all insurance carrier(s) against whom Patient is, or may, assert or maintain any claim for damages and reimbursement for the cost for those services provided by Provider, including, but not limited to, any insurance coverage for Medical Payments, Personal Injury Protection or third party liability insurance payments. A copy of this document shall be as binding as the document bearing original signatures.

SECTION 8. In the event that any Section or provision of this Agreement is determined to be legally void, invalid, or unenforceable, all other Sections and provisions of this Agreement shall remain in full force and effect. Patient may not revoke the assignments and agreements contained in this document without the express written consent of Provider.

IN WITNESS WHEREOF, this agreement has been entered into the day and year set forth below.

_____

Printed Name of Health Care Recipient "Patient"

_____	_____
Date	Patient Signature
_____	_____
Date	Parent Signature if Patient is a Minor
_____	_____
Date	Witness