LONE STAR NEUROLOGY

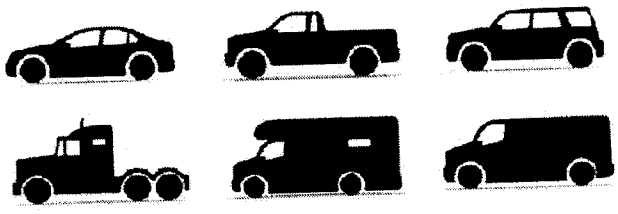
MOTOR VEHICLE ACCIDENT

Date of Accident: _____ Name:_____ DOB:_____

The Vehicle I was driving was a (circle one)

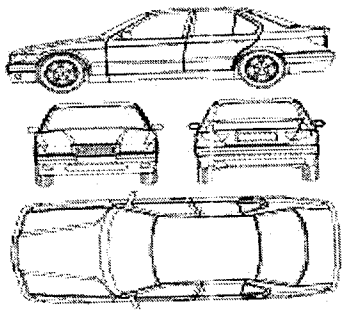
Make/Model: _____

The other vehicle was a (circle one)



Make/Model: _____

MARK YOUR VEHICLES DAMAGE



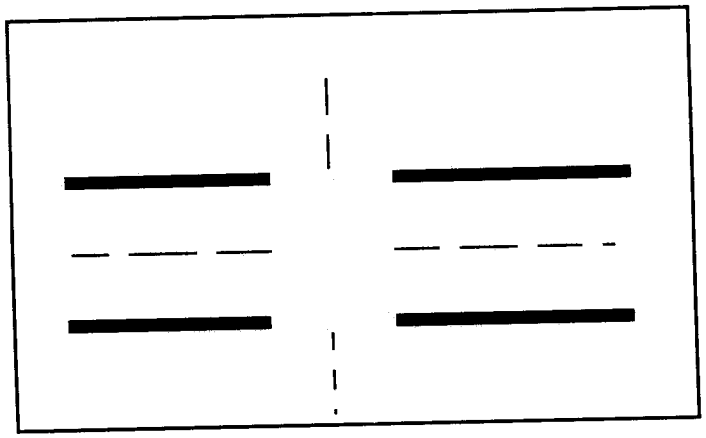
VEHICLE DAMAGE ASSESSMENT

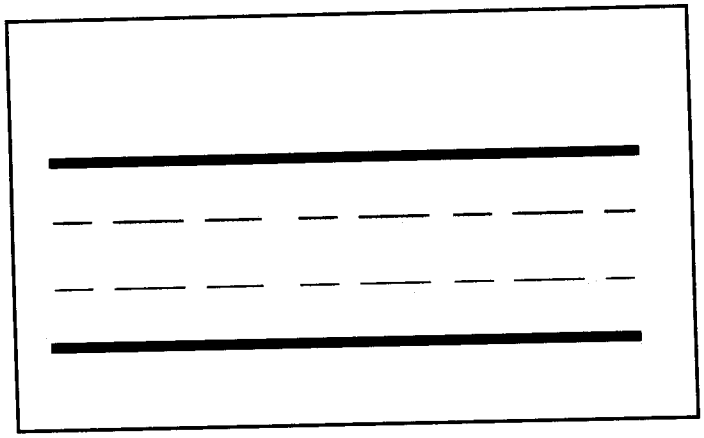
WAS YOUR CAR DRIVEABLE AFTER THE CRASH? Y___ N___

IS YOUR VEHICLES DAMAGE:
LOW___ MIDDLE___ HIGH___ Total Loss___

Approximate Cost of Damage $_____

PLEASE DRAW THE SCENE OF THE ACCIDENT





Did the police arrive? Yes___ No___
Is there a police report? Yes___ No___
Did anyone receive a ticket? Yes___ No___
Did anyone get arrested? Yes___ No___

THE OTHER DRIVER'S INSURACE Co _____

Other Driver's Name _____

Policy _____ Claim Number _____

Did you go to the hospital? Yes___ No___
If Yes, Where?: _____
Do you have health insurance Yes___ No___
Plan Information: _____

YOUR INSURANCE Co _____

Do you have Liability _____ Full Coverage _____

Policy _____ Claim Number _____

SLIP and FALL ACCIDENT

Date of Accident_____

NAME OF BUSINESS OR LOCATION WHERE YOU WERE INJURED?

_____

CITY_____

Did you report the accident to an employee at that business? Yes___ No___

Name of that person _____ Manager? Yes___ No___

Names of any witnesses_____ Phone _____

In which are of the business did the accident occur?

_____

Have you ever been in this business before?

Yes___ No___

What caused you to fall?

_____

Was something of the floor? Yes___ No___

If so what was it? _____

What type of shoes were you wearing?

_____

Were there any warnings in the area where the accident took place? YES___ NO___

IF YES what type of warnings were present? CONES___ SAFETY TAPE___ AREA BLOCKED OFF___ EMPLOYEE___

SOMETHING ELSE: _____

_____

DID YOU GO TO THE HOSPITAL?
YES___ NO___
Name of Hospital: _____
DID YOU GO TO YOUR DOCTOR?
YES___ NO___
Name of Doctor or Clinic

_____

WERE YOU WORKING AT THE TIME OF THE ACCIDENT? YES___ NO___
IF YES what is the name of your employer?

_____

LONE STAR NEUROLOGY

MOTOR VEHICLE ACCIDENT

Date of Accident _____

What type of Vehicle were you driving? Make and Model.

_____

What type of Vehicle was other person driving? Make and Model.

_____

Was your vehicle drivable? Yes_____ No_____

Has your vehicle damage been appraised? Yes_____ No_____

If YES, what was approximate Cost of Damage? _____

Did you go to the EMERGENCY room? Yes_____ No_____

If yes, WHERE? _____

Did the police arrive?	Yes___	No___
Was police report made?	Yes___	No___
Did anyone receive a ticket?	Yes___	No___
Did anyone get arrested?	Yes___	No___
Do you have health insurance?	Yes___	No___

SLIP and FALL ACCIDENT

Date of Accident_____

Name of Business or Location where you were injured?

_____

Did you report the accident to an employee of that business? Yes___ No___

If YES, name of that person_____ Manager? Yes___ No___

Name of any witnesses_____ Phone #_____

In which area of the business did the accident occur?

_____

Have you ever been in this business before? Yes___ No___

What caused you to fall? _____

_____

Was something spilled on the floor? Yes___ No___

If YES, what was it? _____

What type of shoes were you wearing? _____

Were there any warning signs in the area where the accident took place?

Yes___ No___

If YES, what type of warning signs were present? CONES___ SAFETY TAPE___ AREA BLOCKED OFF___ EMPLOYEE___ SOMETHING ELSE: _____

Did you go to the EMERGENCY room? Yes___ No___

If YES, where? _____

Did you go to your Doctor? Yes___ No___

If YES, Name of Doctor or Clinic _____

Were you working at the time of the accident? Yes___ No___

If YES, Name of employer _____

Do you have health insurance? Yes___ No___

LONE STAR NEUROLOGY

BENEFIT ASSIGNMENT RECORD RELEASE PAYMENT AGREEMENT

This agreement is entered into this date by and between _____ hereinafter "Patient" and Lone Star Neurology hereinafter "Provider". Whereas Patient desires to receive healthcare services from Provider and desires to assign certain rights and benefits to Provider as in inducement to cause Provider to wait for payment of such benefits, it is hereby agreed:

Section 1. Patient assigns to Provider any and all benefits payable by Patient's insurance or healthcare plan(s) as a result of charges incurred by Patient for services rendered by Provider. Patient also assigns to Provider any and all contractual rights Patient has against any insurance company, healthcare benefit plan or any other party contractually liable to Patient for payment of healthcare costs incurred by Patient as a result of services rendered by Provider. This assignment of benefits and contractual rights to those benefits shall not exceed the total amount of charges incurred by patient for services rendered by Provider. Patient agrees that payment for services rendered by Provider is due upon receipt of said services and Provider's acceptance of patient assignment of benefits is a convenience to Patient and that Provider may revoke this assignment at any time.

Section 2. Patient thereby directs all insurers and other persons responsible for Patient's healthcare costs to make all payment for the healthcare services rendered by Provider directly to Provider.

Section 3. Patient agrees to waive any applicable statute of limitations which may at any time interfere with Provider's right to collect for services rendered to Patient.

Section 4. Patient agrees that in the event Patient receives any check, draft, or other payment subject to this Agreement, patient will act as a fiduciary agent for Provider and will immediately deliver said check, draft or payment to Provider. Provider agrees to apply the proceeds from the check, draft or payment to Patient's debt for services rendered.

Section 5. A copy of this document shall be as binding as the document bearing original signatures. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in Patient's file and may be picked up by the Patient/insured at any time or will, upon request by the Patient/insured or be mailed to a designated address.

Section 6. Patient agrees to be responsible for any deductibles or co-payments required by the terms of any applicable insurance or healthcare plan. Patient further agrees to pay for any services not covered by Patient's insurance or healthcare plan. A refund, in any, will be calculated upon receipt of payment in full force and effect.

Section 7. In the event that any Section or provision of this Agreement is legally void, invalid or unenforceable, all other sections and provisions of this Agreement shall remain in full force and effect.

Section 8. Provider participates/contracts with many, but not all insurance companies. Provider can be determined dependent on the type of service provided. Contracts are not all the same and certain services may not be covered depending on your benefits. Whether provider participates with an insurance company or not, you must pay your copayment, coinsurance and/or remaining deductible at the time of service. Imaging services may be billed globally or split, technical and professional. You may receive one or two bills. Pain procedures may be billed by up to three providers, physician, facility, and anesthesiology.

IN WITNESS THEREOF, this agreement has been explained to the (patient's) satisfaction and having due knowledge and understanding entered into the day and year set forth below.

_____ _____

Patient **Date**

_____ _____

Guardian (If patient is a minor) **Date**

_____ _____

Witness **Date**