Accident Information Form

Patient Name: ____________________________ Driver's License ___________________ State _________

Address: ___________________________ City: _______________ State: _____________ Zip: __________

Accident Date: ____________ Place of Accident: _____________________ County or City:_____________

Patient Ins: _____________________ Adjuster Name: __________________ Phone: __________________

Address: ___________________________ City: _______________ State: _____________ Zip:__________

Policy Number: ___________________ Claim #: ____________________ Adjuster Fax ________________

AT FAULT Person's Name (if different from above): ____

Insurance co: ___________________ Adjuster Name: __________________ Phone: __________________

Address: ___________________________ City: _______________ State: _____________ Zip: __________

Policy Number: ___________________ Claim #: ____________________ Was a citation issued? Yes / No

Is there any other Insurance related to this accident or injury (workers' compensation, driver/vehicle owner, property or homeowners)? Yes / No

Other Insurance: ___________________ Adjuster Name: __________________ Phone: _________________

Address: ___________________________ City: _______________ State: _____________ Zip: __________

Policy Number: ___________________ Claim #: ____________________ Was a citation issued? Yes / No

Other Insurance: ___________________ Adjuster Name: __________________ Phone: __________________

Address: ___________________________ City: _______________ State: _____________ Zip: __________

Policy Number: ___________________ Claim #: ____________________ Was a citation issued? Yes / No

Attorney/Law Firm: ____ Phone: __________________

Address: ___________________________ City: _______________ State: _____________ Zip: __________

Have you been treated by any other medical providers for this accident or injury? Yes / No

Provider Name: ____________________________________ Balance on Account: $ ___________________

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Please read, initial, sign the document on the next page:

Agreement and Release to Valor Spine Solutions, LLC

This Agreement sets forth the terms of payment to Valor Spine Solutions, LLC, service provider from whom I am about to receive services. I acknowledge and agree to adhere and abide to the entirety of this Agreement. ______ Initials

I, ___________________________ (patient full legal name), the undersigned patient does hereby give authorization for Valor Spine Solutions, LLC, to receive full reimbursement for billed charges from the settlement proceeds. An Agreement has been establish with a Healthcare Provider Lien (recorded or not) and this signed Agreement serves as my Financial Directive and Promise to Pay; along with all favorable state statutes that apply. I give my permission for Valor Spine Solutions, LLC, and their agent to record and serve Notice and Claim of Statutory Health Care Provider Lien; my Financial Directive and Promise to Pay for reimbursement from the settlement funds upon all parties that are liable, including myself for damages arising from the accident which occurred on (__________). Additionally, any subsequent claims arising from this accident in exchange for providing the necessary medical care without requiring payment in full for services received while awaiting my claim(s) to settle. I understand that by doing so I agree and will abide to the terms and conditions of this Agreement with Valor Spine Solutions, LLC. Without any delays Valor Spine Solutions, LLC, will expect prompt payment of the entire amount due (no reductions accepted) on my account as first priority from all settlement/claims or financial compensation(s) regardless of how many liable payers are involved. This will include any payment(s) from past, present or future related or non-related settlements, compromises, judgments verdicts or damages.

I agree to be legally bound and guarantee to fully reimburse Valor Spine Solutions, LLC, from whom I have received care and treatment. Once Valor Spine Solutions, LLC, has been fully compensated, regardless of having a recorded lien, then remaining settlement can then be distributed. I release any legal representative or anyone associated with my claim the authority to challenge the validity, enforceability or amount due to Valor Spine Solutions, LLC, whether a lien has been recorded or not.

I authorize any legal representative or anyone associated with my claim to make full payment promptly from any policy I may receive compensation from (UM/UIM, MedPay, PIP, Third Party or any Liability Coverage). This Agreement acknowledges I have freely given my written consent and authorization in favor of Valor Spine Solutions, LLC, to be fully reimbursed without dispute or delay. I knowingly waive any and all state statues, state or federal laws that would interfere, delay or dismiss Valor Spine Solutions, LLC, from being fully reimbursed (customary fees and charges). I also understand and acknowledge this Agreement is irrevocable and cannot be rescinded or amended.

I understand, agree and promise to pay for all charges associated with my care. Payments will be paid directly to Valor Spine Solutions, LLC, from the settlement, whether a lien was recorded or not and regardless of the insurance companies' reimbursement, settlement or compromise. It is the policy of Valor Spine Solutions, LLC, to establish a lien for my treatment. I do not have the option to utilize my health insurance as full payment for services.

I agree and promise to pay, all administrative expenses associated with processing my claim, including recording and serving notice upon all liable parties, insurance companies, government, state or federal entities which I am or will be receiving payment(s) from.

I, ___________________________ (patient full legal name), authoriz all automobile insurance companies, liable insurance companies, health insurance companies or attorneys to fully disclose any information requested by Valor Spine Solutions, LLC pertaining to my injury promptly.

____ __________________________

Patient Signature Date

____ __________________________

Legal Guardian Date

Valor Spine Solutions, LLC, 825 S. Waukegan Road, Suite A8 #252, Lake Forest, IL 60045
(262) 988-2567