Procedures for PI Cases – First Visit

Please mark off as completed.

Name of Patient:________________________________ Date: ________________________________

1. Get a copy of their health insurance and driver's license in case there are any issues with claim.
2. Have them fill out:
    a. Confidential Patient Information Form
    b. Patient Case History Form
    c. Auto Accident Questionnaire
    d. Diagnostic Imaging Release
    e. Terms of Acceptance
    f. Health Care Authorization Form
    g. Payment for Treatment Form
    h. Patient Verification
    i. Medical Reports and Doctor's Lien
    j. Insurance Info Form
    k. Assignment Form
3. Make sure we have:
    a. Name of insurance company
    b. Address to send claims to
    c. Phone number
    d. Fax number
    e. Medpay number
    f. Adjuster's name (if applicable)
        i. If patient DID NOT bring claim information with them, please let them know they need to have it by next appointment.
4. Enter insurance/billing information into computer (this is under insurance)
5. If they have an attorney:
    a. Enter attorney info into computer (under Patient Info – general- there is an attorney tab)
    b. Fax medical lien for them to sign (use cover fax sheet)

Initials______________________________________ Date____________________________

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name:_______________________ Today's Date:__________

Date of Accident:_______________________

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle type:
- ☐Car ☐Pickup
- ☐Van ☐Truck
- ☐Station Wagon ☐Bus
- ☐Other___________

Vehicle size:
- ☐Subcompact ☐Full-size
- ☐Compact ☐Mini
- ☐Mid-size ☐Light
- ☐Heavy ☐Other___________

Your position in the vehicle:
- ☐Driver
- ☐Passenger -------- Location-------- ☐Left ☐Middle ☐Right
- ☐Other ___________ ☐Front Passenger ☐Rear Passenger ☐Third Seat (rear)

Speed of your vehicle:
- ☐Stopped ☐*Moving Moderately*
- ☐Parked ☐Moving Fast
- ☐Slowing ☐Moving at apprx ____MPH
- ☐Moving Slowly

Why Vehicle was slowed or stopped:
- ☐Traffic Signal ☐Parking
- ☐Pedestrian ☐Traffic
- ☐Stop Sign ☐Busy Intersection

Collision Type:
- ☐Driver Side Impact ☐Head On Collision
- ☐Passenger Side Impact ☐Rear Impact
- ☐Front Impact ☐Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:
- ☐Car ☐Pickup
- ☐Van ☐Truck
- ☐Station Wagon ☐Bus
- ☐Other___________

Vehicle size:
- ☐Subcompact ☐Full-size
- ☐Compact ☐Mini
- ☐Mid-size ☐Light
- ☐Heavy ☐Other___________

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:
- ☐Full daylight
- ☐Dawn
- ☐Dusk
- ☐Night

Road Conditions:
- ☐Dry
- ☐Damp
- ☐Wet
- ☐Snow covered
- ☐Ice covered
- ☐Patchy Ice/Snow

Visibility:
- ☐Excellent
- ☐Good
- ☐Fair
- ☐Poor

Visibility comprimised by:
- ☐Brightness
- ☐Darkness
- ☐Rain
- ☐*Snow*
- ☐Fog
- ☐Traffic

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...
- ☐Totally unaware that the accident was impending
- ☐Aware that the accident was impending
- ☐Aware that the accident was impending and braced for it

Restraints: (check all that apply)
- ☐Seat belt
- ☐Shoulder harness
- ☐No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? ☐Yes ☐No ☐Knocked off by impact

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose conciousness?

- ☐Yes
- ☐No

Immediately following the accident, did you feel...?

- ☐Dizzy
- ☐Weak
- ☐Dazed
- ☐Nervous
- ☐Disoriented
- ☐Nauseated

Were you able to walk unaided?

- ☐Yes
- ☐No

Where did you go...?

- ☐Drove home
- ☐Drove to work
- ☐Was driven home
- ☐Was driven to work
- ☐Drove to hospital
- ☐Drove to school
- ☐Was driven to hospital
- ☐Was driven to school
- ☐Taken to hospital via ambulance

Next day discomfort...?

☐increased ☐decreased ☐same

Did your major complaints exist before the accident?

☐Yes ☐ No

In what areas did you IMMEDIATELY feel pain?

☐Head	Shoulder	☐Left	☐Right	Hip	☐Left	☐Right
☐Neck	Arm	☐Left	☐Right	Thigh	☐Left	☐Right
☐Upper back	Elbow	☐Left	☐Right	Knee	☐Left	☐Right
☐Mid back	Wrist	☐Left	☐Right	Calf	☐Left	☐Right
☐Ribs	Hand	☐Left	☐Right	Ankle	☐Left	☐Right
☐Chest	Fingers	☐Left	☐Right	Foot	☐Left	☐Right
☐Abdomen	Buttock	☐Left	☐Right	Toes	☐Left	☐Right
☐Low Back ☐Pelvis						

In what areas did you experience lacerations (cuts)?

☐Head	Shoulder	☐Left	☐Right	Hip	☐Left	☐Right
☐Neck	Arm	☐Left	☐Right	Thigh	☐Left	☐Right
☐Upper back	Elbow	☐Left	☐Right	Knee	☐Left	☐Right
☐Mid back	Wrist	☐Left	☐Right	Calf	☐Left	☐Right
☐Ribs	Hand	☐Left	☐Right	Ankle	☐Left	☐Right
☐Chest	Fingers	☐Left	☐Right	Foot	☐Left	☐Right
☐Abdomen	Buttock	☐Left	☐Right	Toes	☐Left	☐Right
☐Low Back ☐Pelvis						

At the hospital, what areas were x-rayed?

☐Head	Shoulder	☐Left	☐Right	Hip	☐Left	☐Right
☐Neck	Arm	☐Left	☐Right	Thigh	☐Left	☐Right
☐Upper back	Elbow	☐Left	☐Right	Knee	☐Left	☐Right
☐Mid back	Wrist	☐Left	☐Right	Calf	☐Left	☐Right
☐Ribs	Hand	☐Left	☐Right	Ankle	☐Left	☐Right
☐Chest	Fingers	☐Left	☐Right	Foot	☐Left	☐Right
☐Abdomen	Buttock	☐Left	☐Right	Toes	☐Left	☐Right
☐Low Back ☐Pelvis						

Where did you experience pain on the day FOLLOWING the accident?

☐Head	Shoulder	☐Left	☐Right	Hip	☐Left	☐Right
☐Neck	Arm	☐Left	☐Right	Thigh	☐Left	☐Right
☐Upper back	Elbow	☐Left	☐Right	Knee	☐Left	☐Right
☐Mid back	Wrist	☐Left	☐Right	Calf	☐Left	☐Right
☐Ribs	Hand	☐Left	☐Right	Ankle	☐Left	☐Right
☐Chest	Fingers	☐Left	☐Right	Foot	☐Left	☐Right
☐Abdomen	Buttock	☐Left	☐Right	Toes	☐Left	☐Right
☐Low Back ☐Pelvis						

Was the air bag deployed?

- ☐ Car not equipped with air bag
- ☐ Air bag deployed
- ☐ Air bag not deployed

Position of YOUR head at time of impact?

- ☐ Facing straight ahead
- ☐ Tilted forward
- ☐ Rotated to the left
- ☐ Rotated to the right

Position of Your body at time of impact?

- ☐ Straight
- ☐ Leaning forward
- ☐ Rotated to the left
- ☐ Rotated to the right

Damage to vehicle YOU were in:

- ☐ Incurred minimal damage
- ☐ Incurred moderate damage
- ☐ Incurred severe damage.
- ☐ Was totalled
- ☐ Not known

What position was YOUR headrest in?

- ☐ High position
- ☐ Middle position
- ☐ High position

Was your head thrown...?

- ☐ Backward and then forward
- ☐ Forward then backward
- ☐ To the left ☐ To the left then the right
- ☐ To the right ☐ To the right, then the left

Was your body thrown...?

- ☐ Backward and then forward
- ☐ Forward then backward
- ☐ To the left ☐ To the left, then the right
- ☐ To the right ☐ To the right then the left
- ☐ Across the vehicle
- ☐ Outside the vehicle
- ☐ Under the vehicle

Citations:

- ☐ None issued
- ☐ Yourself
- ☐ Driver of vehicle patient was a passenger of
- ☐ Driver of other vehicle
- ☐ Not sure

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head

- ☐ Steering wheel
- ☐ Dashboard
- ☐ Windshield
- ☐ Armrest
- ☐ *Headrest*
- ☐ Rear view mirror
- ☐ Left door
- ☐ Right door
- ☐ Left window
- ☐ Right window
- ☐ Console
- ☐ *Gear shift*
- ☐ Front seat
- ☐ Backseat

Right Arm

- ☐ Steering wheel
- ☐ Dashboard
- ☐ Windshield
- ☐ Armrest
- ☐ Headrest
- ☐ Rear view mirror
- ☐ *Left door*
- ☐ Right door
- ☐ Left window
- ☐ Right window
- ☐ Console
- ☐ Gear shift
- ☐ Front seat
- ☐ *Backseat*

Left Leg

- ☐ Steering wheel
- ☐ Dashboard
- ☐ Windshield
- ☐ Armrest
- ☐ Headrest
- ☐ Rear view mirror
- ☐ Left door
- ☐ Right door
- ☐ Left window
- ☐ Right window
- ☐ Console
- ☐ Gear shift
- ☐ Front seat
- ☐ Backseat

Left Arm

- ☐ Steering wheel
- ☐ Dashboard
- ☐ Windshield
- ☐ Armrest
- ☐ *Headrest*
- ☐ Rear view mirror
- ☐ Left door
- ☐ Right door
- ☐ Left window
- ☐ Right window
- ☐ Console
- ☐ *Gear shift*
- ☐ Front seat
- ☐ Backseat

Torso

- ☐ Steering wheel
- ☐ Dashboard
- ☐ Windshield
- ☐ Armrest
- ☐ Headrest
- ☐ Rear view mirror
- ☐ *Left door*
- ☐ Right door
- ☐ Left window
- ☐ Right window
- ☐ Console
- ☐ Gear shift
- ☐ Front seat
- ☐ *Backseat*

Right Leg

- ☐ Steering wheel
- ☐ Dashboard
- ☐ Windshield
- ☐ Armrest
- ☐ Headrest
- ☐ Rear view mirror
- ☐ Left door
- ☐ Right door
- ☐ Left window
- ☐ Right window
- ☐ Console
- ☐ Gear shift
- ☐ Front seat
- ☐ Backseat

INSURANCE INFORMATION
MOTOR VEHICLE ACCIDENTS

Note: The information given is not your name and address or the person who hit you. It is the auto insurance companies involved, their addresses, the adjusters, and the claim numbers assigned to your accident.
YOU CAN TAKE THIS HOME WITH YOU, BUT YOU MUST RETURN IT BY YOUR SECOND VISIT. WE WILL BE UNABLE TO SEE YOU UNTIL YOU HAVE ALL THE INFORMATION TO OUR OFFICE.

YOUR CAR INSURANCE INFORMATION (or the person with whom you were riding);
MEDICAL PAY ***(You may or may not have this; if yes, we need the declaration page of your policy.)***:

Insurance Company: ____________________
Street Address: ____________________
City/State/Zip: ____________________
Telephone: ____________________
Claim Number: ____________________
Adjuster's Name: ____________________

INSURANCE COMPANY OF THE PERSON WHO HIT YOU:

Insurance Company: ____________________
Street Address: ____________________
City/State/Zip: ____________________
Telephone: ____________________
Claim Number: ____________________
Adjuster's Name: ____________________

YOUR HEALTH INSURANCE:

Insurance Company: ____________________
Street Address: ____________________
City/State/Zip: ____________________
Telephone: ____________________
Claim Number: ____________________
Adjuster's Name: ____________________

ATTORNEY (if you have retained an attorney due to this accident):

Name: ____________________
Street Address: ____________________
City/State/Zip: ____________________
Telephone: ____________________

(If you are not represented now but retain an attorney at a later date, let us know.)

PATIENT VERIFICATION

I have been advised by this Clinic that the preferred method for payment of treatment fees is for the fees to be paid directly by me as I receive treatment.

- ☐ I do not choose to pay for treatment fees as received, for financial reasons.
- ☐ I do not have health insurance that will cover my treatment for my injuries.
- ☐ I do not want my health insurance to be billed for treatment of my injuries, except in the case that my own liability insurer requires it as condition to qualifying for medical payments coverage.

I authorized this Clinic to bill my own liability insurer for treatment fees I incur. I authorize this Clinic to send notice of the Assignment to my own liability insurer, to the liability insurer of the person I claim caused my injuries, and to the attorney representing me for My Claim. This document is made a part of the Assignment I have signed in favor of the Clinic.

____
Name of Liability Insurer for Person at Fault

____
Name of My Liability Insurer

____
Name of My Attorney

I have received a copy of an Assignment which I have signed in favor of this Clinic and schedule of Treatment Fees.

____
(Signature of Patient, Parent, or Legal Guardian)

____
(Date)

____
(Print or Type Above Name)

____
(Staff Witness)

Payment For Treatment When Patient's Health Insurance Will Not Be Billed

I have been injured. I do not have health insurance or do not want my health insurance to pay for treatment fees. If my automobile insurance will cover my treatment fees, I authorize this Clinic to bill this insurer. Even if no other person is at fault for my injuries caused by an accident, I agree to sign this Clinic's Assignment and related documents, and will provide any information required by the Clinic. I realize that any money which I receive from my automobile insurer for this Clinic's treatment fees must be immediately paid over to this Clinic.

If I believe that one or more persons are a fault for causing my injuries in an accident, I agree to sign this Clinic's Assignment and related documents, and will provide any information required by the Clinic.

I understand that my automobile insurer, or an insurer representing someone I believe to be at fault for causing my injuries, or that persons' attorney, or an attorney representing me in a claim for injuries, may request reports, copies of records, may require a physician from this Clinic to provide deposition testimony or testimony in court, or other information. I understand and agree that I am financially responsible to this Clinic to pay the Clinic's costs for these items, and that the Clinic may request payment in advance for some or all of these items, even if this Clinic's Assignment states otherwise.

I understand and agree that all of my records, including x-rays, are permanent records of this Clinic. I authorized the release of any information relevant to my treatment, including information regarding treatment fees, to insurers and attorneys who are involved with my claim and their respective representatives.

I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND IT.

THIS DOCUMENT IS MADE A PART OF THE ASSIGNMENT.

I HAVE SIGNED IN FAVOR OF THE CLINIC.

I HAVE RECEIVED A COPY OF THIS DOCUMENT.

______________________________ ______________________________

(Signature of Patient) (Date)

____

(Print or type patient name)

____

(Signature of Parent or Legal Guardian)

ASSIGNMENT

I was involved in an accident on or around ____________ [date] in which I was injured for which I have or may have a claim against another person(s) for causing my injuries (including ____________________________) (referenced as "My Claim"), who is insured by: ____________________.

(Name of Person At Fault)

In consideration of the agreement of Douglas R. Portmann, D.C., dba Wards Corner Chiropractic (referenced as the "Clinic") to delay billing me personally for medical treatment rendered until resolution of My Claim:

1. I now assign, without any right to later revoke, a part of any proceeds from my claim equal to the fees incurred by me to this Clinic for all treatment and other services rendered by this Clinic. I am <u>not</u> assigning any legal cause of action in My Claim above, but only prospective proceeds. I also assign to the Clinic my right to enforce the obligation of any insurance company to pay settlement proceeds for any settlement agreement made by or for me in exchange for my signing such insurance company's release of claim. Prior to settlement or other disposition of My Claim, I understand and permit Clinic to pursue payment from any other source but me personally, including medical payments coverage in an automobile liability policy.
2. **This Assignment and all related documents which I have signed in connection with it states the entire agreement and my complete understanding regarding the Clinic's fees. I have not relied on any statements by the Clinic or the Doctor or other information before making this Assignment. I understand that I remain responsible for any Clinic fees not paid out of My Claim.**

____
(Signature of patient)

3. **I understand that it is my responsibility during treatment to remain aware of my cumulative account balance for services rendered. I have received a schedule of treatment fees for this Clinic, *or if I have not, will request this Clinic* for one in writing.**
4. I understand that this is an express contract to pay for the services rendered by this Clinic. I agree to pay my account balance in full and/or direct its payment from My Claim proceeds regardless of whether any other person or entity attempts to or fails to fully reimburse me for it. If I dispute my account balance or treatment rendered, I agree that my remedy will be to resolve it with a separate action from My Claim.
5. <u>NOTICE:</u> I DIRECT <u>ANY INSURANCE COMPANY, ATTORNEY, OR OTHER PERSON WHO HOLDS OR LATER HOLDS ANY PROCEEDS FROM MY CLAIM</u> TO APPLY ANY PROCEEDS FROM MY CLAIM TO MY TOTAL ACCOUNT BALANCE OUT OF THE <u>TOTAL</u> PROCEEDS HELD IN MY BEHALF, UNLESS THE CLINIC CONFIRMS PRIOR PAYMENT OF IT IN WRITING. "TOTAL PROCEEDS" HELD BY AN ATTORNEY FOR MY CLAIM SHALL MEAN PROCEEDS AFTER DEDUCTION OF ATTORNEY FEES.
6. This Assignment is governed by Ohio law. Jurisdiction shall be in Ohio, and venue shall lie in the county in which the Clinic is located, unless required by applicable law to lie in a different county in which I reside.
7. I REALIZE THAT <u>I HAVE NOW GIVEN AWAY A PART OF ANY PROCEEDS FROM MY CLAIM.</u> IF I RECEIVE ANY PROCEEDS FROM MY CLAIM, I AGREE TO IMMEDIATELY DETERMINE IF THIS CLINIC HAS BEEN SEPARATELY PAID IN FULL. UNLESS THE CLINIC CONFIRMS FULL PAYMENT IN WRITING, <u>I REALIZE THAT ANY USE BY ME OF THESE PROCEEDS IS TAKING OR CONVERTING MONEY THAT IS THE PROPERTY OF THIS CLINIC.</u>
8. I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND IT.

____
(Signature of patient)

____
(Date)

____
(Print or type patient name)

This Assignment Has Been Signed On The Clinic Premises:

____
(Signature of Parent or Legal Guardian)

____
(Staff Witness)

7

DIAGNOSTIC IMAGING CONSULTANTS, INC.
3296 W STATE ROUTE 22-3
LOVELAND, OHIO 45140-4587
FAX: (513) 489-4587

ASSIGNMENT OF BENEFITS FOR RADIOGRAPHIC INTERPRETATION

I understand that to insure the highest quality of interpretation of my x-rays, the services of a certified chiropractic radiologist are being utilized. The fee is separate from that of the chiropractic clinic. I also understand that the fees for this service will be submitted to my insurance carrier, worker's compensation, or attorney *in the case of personal injury.*

I understand I may receive a billing statement for: insurance denial, professional fees that have been applied to my deductible or the balance due stated by my insurance company as my responsibility.

In the event that I receive payment for the services I agree to promptly remit payment to Diagnostic Imaging Consultants.

I acknowledge and give my consent to have my x-rays interpreted by Dr. Bryan Hosler, DACBR. I understand that any balance due is my responsibility.

SIGNATURE:______________________________ DATE:______________________________

Healthcare information is sensitive information. It is being sent to us after the appropriate authorization of the patient. We, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized disclosure could subject penalties described in federal law.

The following signature authorizes the release of medical information and also authorizes the assignment of benefits to:

DIAGNOSTIC IMAGING CONSULTANTS, INC.
3296 W STATE ROUTE 22-3
LOVELAND, OHIO 45140-4587

SIGNATURE:______________________________ DATE:______________________________

WITNESS:______________________________

DIAGNOSTIC IMAGING CONSULTANTS, INC.
3296 W STATE ROUTE 22-3
LOVELAND, OHIO 45140-4587
FAX: (513) 489-4587

***Please make sure all information is completed with each set of films.
***Attach assignments of benefits form signed by patient.

PATIENT NAME ________________________ CLINIC ______________________________
ADDRESS ______________________________ CITY ______________________________

STATE ________________ ZIP ______________ PHONE ______________________________

D.O.B. ____________________ MARITAL STATUS: S M D W

SOCIAL SECURITY NUMBER (REQUIRED): ____________________ SEX: F M

INSURANCE COMPANY (ONLY) ATTACH COPY OF CARD

INSURED'S NAME ____

RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

INSURANCE COMPANY ____

ADDRESS ________________________________ PHONE ____________________________

POLICY # ______________________________ GROUP # ____________________________

ATTORNEY (ONLY)

ATTORNEY'S NAME ____

ADDRESS ____

STATE ________________ ZIP ______________ PHONE ______________________________

PATIENT HISTORY

PRESENT COMPLAINT ____

TRAUMA? YES NO EXPLAIN ____

PAST MEDICAL HISTORY ____

REFERRING DOCTORS CONCERNS/QUESTIONS _____________________________________

____

***DATE OF INJURY ____

***DIAGNOSIS CODE NUMBERS ____

9

MEDICAL REPORTS AND DOCTOR'S LIEN

Wards Corner Chiropractic, Inc.
550 Wards Corner Road
Suite 101
Loveland, Ohio 45140
513 677 6787

I authorize this Doctor's office to furnish you, my Attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my Attorney, to pay directly to said Doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said Doctor. I hereby further give a lien on my case to said Doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my Attorney, a subsequent Attorney, or myself as the result of the injuries for which I have been treated or injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said Doctor for all medical bills submitted by said Doctor for service rendered to me and that this agreement is made solely for said Doctor's additional protection and in consideration of the Doctor's awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the Doctor's office. I have been advised that if my Attorney does not wish to cooperate in protecting the Doctor's interest, the Doctor will not await payment but will require me to pay on my account and keep it on a current basis.

Date: ________________ Patient's Signature: ______________________________

The undersigned being Attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said Doctor above named.

Date: ________________ Attorney's Signature: ______________________________

Please date, sign and return one copy to Doctor's office.
Keep a copy for your records.
A photocopy of this form shall be as valid as the original.