PERSONAL INJURY QUESTIONNAIRE

Name _____ Date of Birth _____ Phone _____

Address _____ City _____ State _____ Zip _____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____ Agent's Name _____

Driver/Other Vehicle _____ Ins. Co. _____ Policy # _____

Have you retined an attorney? ( ) Yes ( ) No Name _____

Were there any witnesses? ( ) Yes ( ) No Name(s) _____

NATURE OF ACCIDENT:

1. Date of Accident _____ Time of Day _____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle: _____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West

   on (name of street) _____
5. What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West

   on (name of street) _____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Were you knocked unconscious? ( ) Yes ( ) No If so, for how long? _____
8. Were police notified? ( ) Yes ( ) No
9. In your own words, please describe accident: _____

   _____

   _____

   _____
10. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe in detail: _____

    _____

    _____
11. Please describe how you felt:

    a. DURING the accident: _____

    b. IMMEDIATELY AFTER the accident: _____

    c. LATER THAT DAY: _____

    d. THE NEXT DAY: _____
12. What are your PRESENT complaints and symptoms? _____

    _____

13. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No If yes, please describe: _____

_____

14. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If yes, please describe: _____

_____

15. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received: _____

_____

16. Where were you taken after the accident? _____

17. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name and address: _____

_____

What type of treatment did you receive? _____

_____

18 Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

19. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

( ) Headache	( ) Irritability	( ) Numbness in Toes	( ) Face Flushed	( ) Feet Cold
( ) Neck Pain	( ) Chest Pain	( ) Shortnessof Breath	( ) Buzzing in Ears	( ) Hands Cold
( ) Neck Stiff	( ) Dizziness	( ) Fatigue	( ) Loss of Balance	( ) Stomach Upset
( ) Sleeping	( ) Pins & Needles in Arms	( ) Lights Bother Eyes	( ) Loss of smell	( ) Cold Sweats
( ) Nervousness	( ) Pins & Needles in Legs	( ) Loss of Memory	( ) Loss of Taste	( ) Fever
( ) Tension	( ) Numbness in Fingers	( ) Ears Ring	( ) Diarrhea	( ) _____

Symptoms Other Than Above _____

20. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete this question:

a. Last Day Worked: _____

b. Type of Employment: _____

c. Present Salary: _____

d. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving:

_____

21. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe in detail: _____

_____

_____

22. Other pertinent information: _____

_____

_____

_____

_____ _____

DATE PATIENT'S SIGNATURE

WOLPH CHIROPRACTIC, INC.

640 S. WINTERGARDEN RD.
BOWLING GREEN, OH 43402
419.353.6394
Fax: 419.354.8341
Email: wolphchiro@yahoo.com

ASSIGNMENT (Doctor's Lien)

I was involved in an accident on _____(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 or Company at Fault)
In consideration of the agreement of **Wolph Chiropractic & Acupuncture** to bill my Medpay (patient's auto insurance company) for medical treatment rendered until such funds are exhausted or 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 Wolph Chiropractic for all treatment and other services rendered by this Wolph Chiropractic. I am **not** assigning any legal cause of action in My Claim above, but only prospective proceeds. I also assign to Wolph Chiropractic 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 Wolph Chiropractic to pursue payment from any other source including medical payments coverage in an automobile liability policy.
2. **This Assignment and related documents which I have signed in connection with it states the entire agreement and my complete understanding regarding Wolph Chiropractic's fees. I have not relied on any statements by Wolph Chiropractic or the Doctor or other information before making this Assignment. I understand that I remain responsible for any Wolph Chiropractic 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 Wolph Chiropractic, or if I have not, will request from Wolph Chiropractic for one in writing.**
4. I understand that this is an express contract to pay for the services rendered by Wolph Chiropractic. 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. **NOTICE: I DIRECT ANY INSURANCE COMPANY, ATTORNEY, OR OTHER PERSON WHO HOLDS OR LATER HOLDS ANY PROCEEDS FROM MY CLAIM TO APPLY ANY PROCEEDS FROM MY CLAIM TO MY TOTAL ACCOUNT BALANCE OUT OF THE TOTAL PROCEEDS HELD IN MY BEHALF, UNLESS WOLPH CHIROPRACTIC 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. Ohio law governs this Assignment. Jurisdiction shall be in Ohio, and venue shall lie in the county in which Wolph Chiropractic is located, unless required by applicable law to lie in a different county in which I reside.
7. **I REALIZE THAT I HAVE NOW GIVEN AWAY A PART OF ANY PROCEEDS FROM MY CLAIM. IF I RECEIVE ANY PROCEEDS FROM MY CLAIM, I AGREE TO IMMEDIATELY DETERMINE IF WOLPH CHIROPRACTIC HAS BEEN SEPARATELY PAID IN FULL. UNLESS WOLPH CHIROPRACTIC CONFIRMS FULL PAYMENT IN WRITING, I REALIZE THAT ANY USE BY ME OF THESE PROCEEDS IS TAKING OR CONVERTING MONEY THAT IS THE PROPERTY OF WOLPH CHIROPRACTIC.**
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 Premises:

_____ _____
(SIGNATURE OF PARENT OR LEGAL GUARDIAN) **(WOLPH CHIROPRACTIC WITNESS)**

_____ _____
(Attorney's Signature) **(DATE)**

Wolph Chiropractic

123 S. Main St.
Fostoria, Ohio 44830
419.436.0616
640 S. Wintergaden Rd.
Bowling Green, Ohio 43402
419.353.6394

Attention: Patients involved in personal injury/auto accident cases

Re: Billing procedures

To Whom It May Concern,

Please be advised of our office policy if you are seeking care in our office due to injuries sustained in an accident.

If a third party (at-fault driver's insurance company) is responsible for all medical care and or making payment for your care we must properly document **all** care that takes place in our office. If multiple areas and joints were injured and we are addressing multiple areas, we must charge for ALL services rendered and all modalities we use for each visit.

We cannot properly document and defend your case if charges are waived. We are often called to testify in court, provide depositions, and narrative reports to substantiate all of your injuries and all of the care you received. If we do not charge for all services, your settlement will be diminished and there will be no proof of the level of injury. Your settlement amount is based on your medical bills. If we reduce your bill, waive charges, or provide discounts—your settlement will be reduced as well.

We must provide lawyers and insurance companies with a full picture of what took place in our office. We often take cases and then wait several years for any payment. We often spend many hours writing reports, and consulting with attorneys. We do not have any way to know if your case will wind up in court, and if or when a settlement will be made. We are offered no protection by the law of Ohio that the patient will make payment at the time of settlement.

As a rule, there is a lot of extra time and money involved with personal injury cases. Therefore, if you choose to have our office represent and defend your case with correspondence with attorneys or insurance companies, we will agree to wait for payment in full at the time of your settlement if you do not have Medpay under your auto insurance policy or your treatment exceeds the maximum dollar amount with your Medpay policy.

However, if you want to have discounted (time-of-service) rates, we will need you to pay for each visit as you go, and also agree to sign papers that state you do not want us to represent your case in any way (depositions, phone calls, narrative reports, medical necessity proof, or courtroom appearances).

Fees for personal injury cases are the same as any other patient; however, exams, updates, narrative report fees, may be added and no insurance discounts or time-of-service payment discounts will be offered. We will only provide our daily notes if you agree to waive our responsibility in defending your case.

If you have further questions with regard to our billing policy, please let us know.

Sincerely,
Drs. Clay & Lora Wolph