AUTOMOBILE COLLISION QUESTIONNAIRE

General Information:

Name ______________________________ Phone Number ______________

Address ____________________City ______________ State_____ Zip __________

Nature of Collision:

1. Date of Collision? ________________ 20_____ Time: ___________ AM PM
2. Where did the collision occur? City/Town: ______________ State __________
3. Please describe in detail how your collision occurred? ______________________

____

____

4. Were you the: ◯ driver ◯ passenger ◯ pedestrian
5. If passenger, were you in the: ◯ front seat ◯ right rear seat ◯ left rear seat
6. What type of vehicle were you in? ______________________________
7. What type was the other vehicle? ______________________________
8. Did your vehicle strike the other vehicle? ◯ yes ◯ no
9. Was your car struck by the other vehicle? ◯ yes ◯ no
10. Was the impact from: ◯ the front ◯ the rear ◯ the left side ◯ the right side
11. What was the approximate speed at the time of the impact?

    Your vehicle _______mph Other vehicle _______mph
12. How much damage was done to **your** vehicle $______ The other vehicle $ _____ ☐ Not Sure
13. What was the weather at the time of the collision? ◯ dry ◯ wet ◯ icy
14. Was your vehicle in: ◯ park ◯ neutral ◯ in gear ◯ moving ◯ stopped
15. Were your brakes being applied? ◯ yes ◯ no
16. Was your vehicle shoved: ◯ forward ◯ backward ◯ sideways
17. Were you shoved: ◯ forward ◯ whipped backward ◯ sideways
18. Did your seat have a head restraint (headrest?) ◯ yes ◯ no
19. If yes, what was the position? ◯ low ◯ midposition ◯ high
20. Did your head ride over the headrest? ◯ yes ◯ no
21. Did your hat/glasses end up in the back seat or rear window? ◯ yes ◯ no
22. Did any other part of your body hit the interior of the vehicle? ◯ yes ◯ no
23. If yes, please specify: ☐ seatbelt restraints ☐ steering wheel ☐ dashboard

    ☐ windshield ☐ side door ☐ side window ☐ Other ____________________
27. Which part of your body? ☐ chest ☐ head ☐ chin ☐ face ☐ R L knee

    ☐ R L shoulder ☐ R L hand ☐ Other ______________________________

28. Were you holding on to the steering wheel? ◯ yes ◯ no
29. Did you brace your arms against the dash? ◯ yes ◯ no
30. Did you brace your legs against the floorboard? ◯ yes ◯ no
31. Was your ankle turned? ◯ yes ◯ no
32. Did the vehicle go into a spin or roll as a result of the impact? ◯ yes ◯ no
33. If yes, explain: ______________________________
34. At the point of impact, where did you experience pain? Be specific: ______________________________

____

____

35. Immediately after the accident were you: ◯ conscious ◯ dazed ◯ unconscious
36. What is the next thing you remember immediately after the impact? ______________________________

____

37. If you lost consciousness, how long? ______________________________
38. Were you wearing a seat belt? ◯ yes ◯ no
39. Did the belt have a shoulder harness? ◯ yes ◯ no
40. If yes, did it contribute to the pain you are experiencing? ◯ yes ◯ no
41. At the time of impact were you: ◯ looking straight ahead ◯ looking to the right ◯ looking to the left ◯ looking down ◯ looking up
43. Did the seat break as a result of the impact? ◯ yes ◯ no
44. Were you braced for the impact? ◯ yes ◯ no
45. Were you surprised by the impact? ◯ yes ◯ no
46. Did you go to the hospital? ◯ yes ◯ no
47. If yes, when? ◯ right after the accident ◯ next day ◯ other: ______________________________
48. If yes, how did you get there? ◯ ambulance ◯ other: ______________________________
49. If by ambulance, did the ambulance attendants place you in a: ◯ neck brace ◯ back brace ◯ Other: ______________________________
50. Any medication or medical supplies given? ______________________________
51. Did you have x-rays taken at the hospital? ◯ yes ◯ no
52. If you went to the hospital, please answer the following:

Name of hospital ______________________________

Name of doctor ______________________________

Diagnosis ______________________________

Treatment Received ______________________________

____

53. Did you consult any other doctors prior to coming to this office? ◯ yes ◯ no
54. If yes, who and type of doctor/therapist? ______________________________

____

55. What treatment did you receive? ______________________________

56. Did the treatment help? ______________________________

57. Describe the doctor's diagnosis? ______________________________

58. Are you still under a doctor's care? ◯ yes ◯ no If yes, please explain: ______________

____

59. If no, when were you last treated? ______________________________

Past History:

1. Have you ever injured this area before? ◯ yes ◯ no If yes, when? ______________
2. Have you been involved in any previous accidents of any kind (personal injury, automobile collision or worker's compension)? ◯ yes ◯ no If yes, please explain dates and details ____

____

____

3. Have you enjoyed good health prior to this accident? ◯ yes ◯ no If no, please explain:

____

Present Information/Disability:

1. Have you returned to work? _______, If yes, date returned to work ______________
2. Job description ______________________________
3. Are your work activities restricted as a result of this accident? ______, If yes, please explain:

____

____

4. Do you notice any activity restrictions as a result of this injury? ______, If yes, please describe:

____

____

5. Since this injury are your symptoms: ◯ improving ◯ getting worse ◯ staying the same
   Please explain: ______________________________

____

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient Signature ______________________________ Date ______________

Witness ______________________________ Date ______________

Symptoms

Patient ______________________ Date ____________ Date of Injury ___________

Please fill in all symptoms you currently have that you did not have before the accident.

Orthopedic & Musculoskeletal Symptoms

- ❑ "Clunk" Sound with Neck Movements
- ❑ Neck Pain
- ❑ Upper Back Pain
- ❑ Low Back Pain
- ❑ Shoulder Pain ❑ Left ❑ Right
- ❑ Upper Arm Pain ❑ Left ❑ Right
- ❑ Elbow Pain ❑ Left ❑ Right
- ❑ Forearm Pain ❑ Left ❑ Right
- ❑ Wrist Pain ❑ Left ❑ Right
- ❑ Hand Pain ❑ Left ❑ Right
- ❑ Hip Pain ❑ Left ❑ Right
- ❑ Upper Leg Pain ❑ Left ❑ Right
- ❑ Knee Pain ❑ Left ❑ Right
- ❑ Lower Leg Pain ❑ Left ❑ Right
- ❑ Ankle Pain ❑ Left ❑ Right
- ❑ Foot Pain ❑ Left ❑ Right
- ❑ Jaw Pain
- ❑ Clicking in Jaw
- ❑ Pain when Chewing
- ❑ Face Pain
- ❑ Chest Pain
- ❑ Stomach Pain
- ❑ Bruise/Contusion to ______________
- ❑ Abrasion/Scrape to______________
- ❑ Other Symptom ______________
- ❑ Other Symptom ______________

Neurological Symptoms

- ❑ Numb/Tingling Arm/Hand ❑ Left ❑ Right
- ❑ Numb/Tingling Leg / Foot ❑ Left ❑ Right
- ❑ Weakness Arm / Hand ❑ Left ❑ Right
- ❑ Weakness Leg / Foot ❑ Left ❑ Right

Symptoms Associated with Injuries

- ❑ Range of Motion Problems
- ❑ Headaches
- ❑ Muscle Spasms
- ❑ Dizziness
- ❑ Visual Disturbances
- ❑ Sleep Disruption
- ❑ Radiating Pain
- ❑ Anxiety
- ❑ Depression
- ❑ I am taking over-the-counter pain meds

Brain/Neuropsych/MTBI Symptoms

- ❑ Wanting to be Alone
- ❑ Sleepiness
- ❑ Nausea/vomiting
- ❑ Difficulty Concentrating
- ❑ Day Dreaming/Staring Mindless Staring
- ❑ Mood Swings
- ❑ Agitation
- ❑ Sadness or tearful
- ❑ Blurry Vision
- ❑ Double Vision
- ❑ Disoriented
- ❑ Confused
- ❑ Difficulty Speaking
- ❑ Feelings of Isolation from Others
- ❑ Attention Problems
- ❑ Appetite Change
- ❑ Pupils Different Sizes
- ❑ Room Spins/ Woozy Feeling
- ❑ Balance Problems
- ❑ Difficulty Walking
- ❑ Difficulty Focusing/Easily Distracted
- ❑ Very Tired
- ❑ Dozing During The Day
- ❑ Personality Change
- ❑ Can't Remember Numbers
- ❑ Reading Problems
- ❑ Writing Problems
- ❑ Difficulty with Adding/Subtracting
- ❑ Poor Attention
- ❑ Difficulty Learning New Things
- ❑ Difficulty Understanding
- ❑ Difficulty Remembering Things
- ❑ Re-reading Things to Understand It
- ❑ Anger
- ❑ Difficulty Making Decisions
- ❑ Change in Sexual Functioning
- ❑ Reduced Confidence
- ❑ Helplessness
- ❑ Apathy (Don't Care)
- ❑ Irritable
- ❑ Change in Sense of Taste or Smell
- ❑ Flashbacks to Accident
- ❑ Impatience
- ❑ Frustration
- ❑ Hearing Problems
- ❑ Difficulty Planning or Organizing

Doctor's Notes

____
Doctor's Initials
Wolf Chiropractic Center

Wolf Chiropractic Center, PS Inc.

Wolf Chiropractic Center
Dr. Jeanine Wolf-Richter
1010 so 336th St, Suite 102
Federal Way, WA 98003
Office: 253-838-7300
Fax: 253-838-0505

PAIN DRAWING

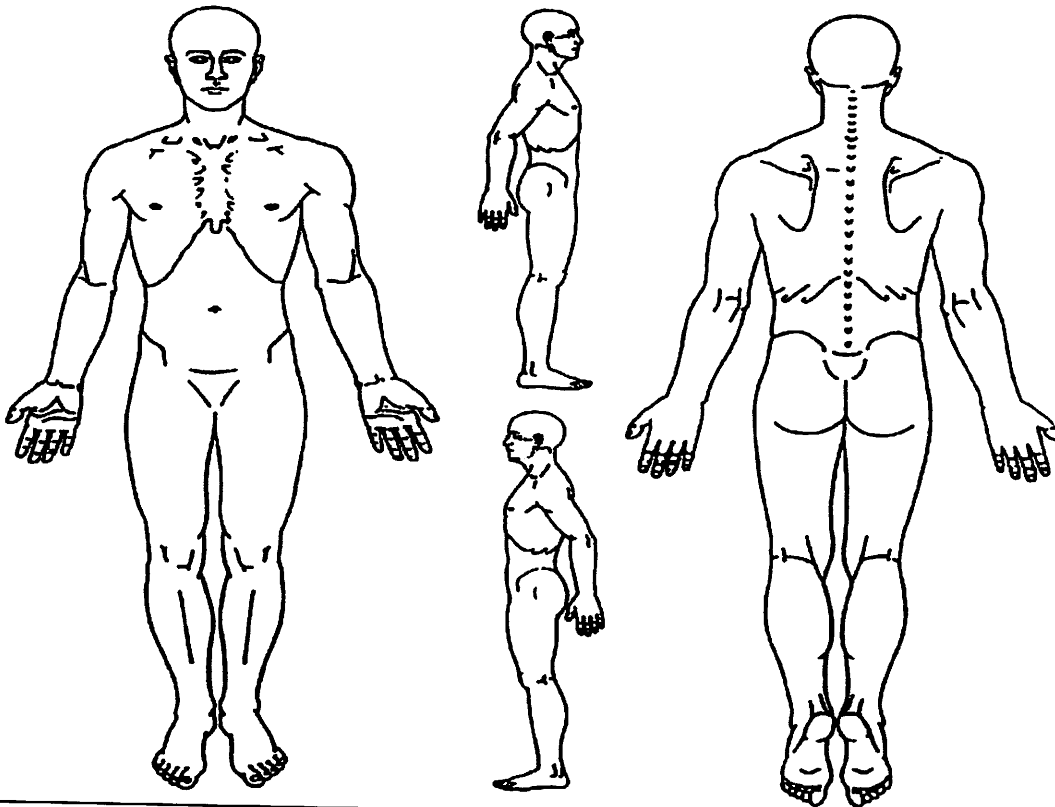
____
Today's Date (MM/DD/YYYY)

____
Your Name

Tell Us Where You Hurt

Please Read Carefully: Mark the areas on your body where you feel pain. Include all affected areas. To mark areas of radiation, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the symbols listed below:

Ache	=	>>>>>>	Numbness	=	++++++	Pins & Needles	=	oooooo
Burning	=	xxxxxx	Stabbing	=	//////	Throbbing	=	~~~~~~



SEVERITY OF PAIN: List area of pain and circle the number corresponding to your pain level (1= no pain, 10= severe pain)

Example: *Neck pain*
1 2 3 4 5 6 7 (8) 9 10

1. ______________________
1 2 3 4 5 6 7 8 9 10

2. ______________________
1 2 3 4 5 6 7 8 9 10

3. ______________________
1 2 3 4 5 6 7 8 9 10

4. ______________________
1 2 3 4 5 6 7 8 9 10

5. ______________________
1 2 3 4 5 6 7 8 9 10

6. ______________________
1 2 3 4 5 6 7 8 9 10

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School (p. 1 of 2)

Patient ______________________ Date ___________ Date of Injury ___________

☐ Initial ☐ Update

Please check all that apply to your EXERCISE & SPORTS Activity *because of the accident.*

- ☐ My exercise was affected by this crash
- ☐ I go to the gym & work out in pain
- ☐ I no longer go to the gym to work out
- ☐ I run but in pain
- ☐ I no longer run
- ☐ I take walks & have pain while walkiing
- ☐ I no longer take walks
- ☐ I used to make income at sports
- ☐ I have lost sports income since crash
- ☐ I am an amateur athlete
- ☐ I am a professional athlete
- ☐ ______________________
- ☐ ______________________
- ☐ I have gained _____ pounds since the accident
- ☐ I had to quit my ________ team after the accident
- ☐ I had to quit my ________ team after the accident
- ☐ I had to quit my ________ team after the accident
- ☐ I had to quit my ________ team after the accident
- ☐ I don't enjoy the sport of _________ anymore
- ☐ I didn't enjoy the sport of ________ for ____ weeks
- ☐ I don't enjoy the sport of _________ anymore
- ☐ I didn't enjoy the sport of ________ for ____ weeks
- ☐ I don't enjoy the sport of _________ anymore
- ☐ I didn't enjoy the sport of ________ for ____ weeks
- ☐ I don't enjoy the sport of _________ anymore
- ☐ I didn't enjoy the sport of ________ for ____ weeks

Please check all that apply to your HOBBY Activities *because of the accident.*

- ☐ My hobbies were affected by accident
- ☐ Hobby #1 ________________
- ☐ I can't do hobby #1 anymore
- ☐ I do hobby #1 but in pain
- ☐ I have lost money from not doing #1
- ☐ I didn't do hobby #1 for _____ weeks
- ☐ Hobby #2 ________________
- ☐ I can't do hobby #2 anymore
- ☐ I do hobby #2 but in pain
- ☐ I have lost money from not doing #2
- ☐ I didn't do hobby #2 for _____ weeks
- ☐ Hobby #3 ________________
- ☐ I can't do hobby #3 anymore
- ☐ I do hobby #3 but in pain
- ☐ I have lost money from not doing #3
- ☐ I didn't do hobby #3 for _____ weeks
- ☐ Hobby #4 ________________
- ☐ I can't do hobby #4 anymore
- ☐ I do hobby #4 but in pain
- ☐ I have lost money from not doing #4
- ☐ I didn't do hobby #4 for _____ weeks
- ☐ ______________________

Please check all that apply to your TRAVEL Activities *because of the accident.*

- ☐ Business travel was affected by crash
- ☐ Pleasure travel was affected by crash
- ☐ I hurt driving in my own car
- ☐ I am in too much pain to drive
- ☐ I hurt when a passenger in a car
- ☐ I am in too much pain to sit in a car
- ☐ I have anxiety when I'm in a car
- ☐ I hurt when I'm on an airplane
- ☐ I am in too much pain to travel by plane
- ☐ Travel Plan #1 ________________
- ☐ I did not go on travel plan #1
- ☐ I went, but did not enjoy #1 as much
- ☐ I went and the accident had no effect on #1
- ☐ Travel Plan #2 ________________
- ☐ I did not go on travel plan #2
- ☐ I went, but did not enjoy #2 as much
- ☐ I went and the accident had no effect on #2
- ☐ I missed time with my family/friends b/c can't travel

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Living, & School (p. 2 of 2)

Patient ____________________________ Date ____________ Date of Injury ___________

☐ Initial ☐ Update

Please check all the DAILY LIVING Activities that cause you pain *because of the accident.*

- ☐ Dressing
- ☐ Putting on pants
- ☐ Putting on shoes
- ☐ Tying my shoes
- ☐ Putting on shirt
- ☐ Drying my hair
- ☐ Combing my hair
- ☐ Washing my hair
- ☐ Taking a shower
- ☐ Taking a bath
- ☐ Leaning forward
- ☐ Laying in bed
- ☐ Sitting in my favorite chair
- ☐ Sleeping
- ☐ Going out with my friends
- ☐ Sitting in a restaurant
- ☐ Shopping
- ☐ Driving to/from work
- ☐ Sitting in Church
- ☐ Playing with my children
- ☐ Caring for my children
- ☐ Bending at the waist
- ☐ Sitting in a movie theater
- ☐ Exercise
- ☐ Eating
- ☐ Stooping
- ☐ Squatting down
- ☐ Kneeling
- ☐ Brushing my teeth
- ☐ Riding in a car
- ☐ Opening a jar
- ☐ Lifting a pan when cooking
- ☐ Closing the trunk on my car
- ☐ Opening the garage door
- ☐ Using my home computer
- ☐ Climbing stairs
- ☐ Going down stairs
- ☐ Sexual activity
- ☐ Turning my head to left or right
- ☐ Holding my head up all day
- ☐ Watching TV
- ☐ I have pain sitting & doing nothing
- ☐ Talking on the phone
- ☐ Reading
- ☐ Writing
- ☐ Opening doors
- ☐ Drying with a towel after a bath or shower
- ☐ Life has become a chore just to do normal things
- ☐ It is depressing to live like this
- ☐ ________________________________
- ☐ ________________________________
- ☐ ________________________________
- ☐ ________________________________
- ☐ ________________________________
- ☐ ________________________________
- ☐ ________________________________
- ☐ ________________________________
- ☐ ________________________________

Please check all that apply to your SCHOOL & EDUCATION Activities *because of the accident.*

- ☐ School was affected by the accident
- ☐ I am a student at ________________
- ☐ I am in the ____________ year/grade
- ☐ I was ☐ full time ☐ part time
- ☐ I am now ☐ full time ☐ part time
- ☐ I had to take fewer classes b/c of crash
- ☐ I missed _____ days of school
- ☐ I had to drop out of school b/c of crash
- ☐ My grades are lower since the crash
- ☐ I have pain carrying my school books
- ☐ I hurt sitting in class more than _______ minutes
- ☐ My neck hurts when I look down to read
- ☐ I don't learn as quickly as before the crash
- ☐ I don't learn things as well as before the crash
- ☐ I have difficulty concentrating in class
- ☐ It takes much longer to study/do my homework
- ☐ ________________________________
- ☐ ________________________________

____________________________ ____________________

Signature of Patient Date

Duties Performed Under Duress at Work and Home

Patient ______________________________ Date _____________ Date of Injury ____________

☐ Initial ☐ Update

Please check all that apply to your WORK *because of the accident.*

- ☐ I go to work but work in pain
- ☐ I limit my work activities
- ☐ Bending at work hurts
- ☐ Stooping at work hurts
- ☐ Sitting at work hurts
- ☐ Using the Computer at work hurts
- ☐ Pushing at work hurts
- ☐ Pulling at work hurts
- ☐ Kneeling at work hurts
- ☐ I have lost status in my company
- ☐ I have lost job security
- ☐ I didn't get a promotion
- ☐ I don't enjoy work as much as before
- ☐ I doze off at work
- ☐ I take unpaid time off work to go to Dr.
- ☐ I daydream at work more than before
- ☐ I feel tired at work
- ☐ ________________________________
- ☐ ________________________________
- ☐ I work in pain because I have bills to pay
- ☐ I can't take time off because I would lose my job
- ☐ I keep working so I don't lose status at company
- ☐ My business would fail if I took time off
- ☐ I believe in working even when I'm in pain
- ☐ I feel obligated to work even though I'm in pain
- ☐ My business would lose money if I took time off
- ☐ My work is not as good as it was before accident
- ☐ My boss reprimanded me for poor performance
- ☐ I got a different job within the same company
- ☐ I got a different job in another company
- ☐ I make less money than before the accident
- ☐ I cannot do the same work/job as before accident
- ☐ I can't concentrate as well at work
- ☐ I take paid time off to go to Dr.
- ☐ I make mistakes at work I didn't used to
- ☐ I hide my poor work performance from my boss
- ☐ ________________________________
- ☐ ________________________________

Please check all that apply to your HOME/DOMESTIC duties *because of the accident.*

- ☐ My house is not as clean now
- ☐ My yard is not as neat now
- ☐ My garden is not as productive now
- ☐ I do yard work, but do it in pain
- ☐ I cannot do my normal yard work
- ☐ I do house work, but do it in pain
- ☐ I cannot do my normal house work
- ☐ Doing laundry hurts me
- ☐ I cannot do laundry now
- ☐ Washing dishes hurts me
- ☐ I cannot wash dishes now
- ☐ Vacuuming hurts me
- ☐ I cannot vacuum now
- ☐ Cooking hurts me
- ☐ I cannot cook now
- ☐ Washing the car hurts me
- ☐ I cannot wash my car
- ☐ ________________________________
- ☐ ________________________________
- ☐ I cannot take time off because I care for children
- ☐ I have _____ children ages ________________
- ☐ I had to hire a paid housekeeper
- ☐ I asked someone for unpaid housekeeping help
- ☐ I had to hire a paid gardener
- ☐ I asked someone for unpaid yard work help
- ☐ Mowing the lawn hurts me
- ☐ I cannot mow the lawn
- ☐ Taking out the trash hurts me
- ☐ I cannot take out the trash
- ☐ I do not enjoy my gardening/yardwork like I used to
- ☐ I do not enjoy my housework like I used to
- ☐ Gardening hurts me
- ☐ I cannot do my gardening at all since the accident
- ☐ Others living with me do my share of the work now
- ☐ Others living with me do my share of the yard work
- ☐ Others living with me do my share of the gardening
- ☐ ________________________________
- ☐ ________________________________

________________________________ ________________________

Signature Date

Financial Agreement

In an effort to maintain compliance with state and federal regulations, managed care and preferred providers agreements, as well as billing and coding guidelines, we have adopted the following financial policies.

1. Our clinic has established a single fee schedule that applies to all patients for each service provided.

2. You may be entitled to a network or contractual discount under the following circumstances:
   a. We are a participating provider in your health plan.
   b. You are covered by a state or federal program with a mandated fee schedule.
   c. You pay at the time of service. This discount is available regardless whether you are insured or not, unless prohibited by provider contract, but you must pay at the time of service to qualify. A receipt will be provided so that you can submit it to the appropriate insurance company or companies for reimbursement. We will not submit billings when time of service discount is used, unless required by provider contract.

Please select one:

❑ I choose to use the time of service discount and will pay at the time that I receive services from Wolf Chiropractic Center. I understand that you will NOT be submitting my bills to any other party.

❑ I choose NOT to pay at the time of service and request that Wolf Chiropractic Center bill the following third party for the services that I receive. I understand that this makes me ineligible for the time of service discount.

❑ Health Insurance Plan ❑ Medicare ❑ Other: ____________________

❑ Worker's Compensation Plan ❑ Automobile Insurance

Please come to each visit prepared to pay all insurance co-pays, co-insurances or deductibles required by your health insurance as you are responsible for these amounts.

If your insurance company has not paid a claim within 60 days of submission, you agree to take an active part in the resolution of your claim. If your insurance company has not paid within ninety 90 days of submission, you are responsible for the payment of any outstanding balance. Payment is due upon receipt of statement from our office.

Regardless of the selection above, I understand that ultimately **I am financially responsible** for the services that I receive at Wolf Chiropractic Center.

______________________________ SIGNATURE

______________________________ DATE

Dr. Jeanine Wolf Richter
622 S. 320th St., Ste B
Federal Way, WA 98003
(253) 838-7300

CONTRACTUAL GUARANTEE OF PAYMENT FOR HEALTH CARE SERVICES

I hereby authorize and direct you, my attorney, to pay directly to Wolf Chiropractic Center PS., Inc such sums as may be due and owing for health care services for injuries arising from a motor vehicle accident. I hereby authorize my attorney and involved insurance companies to withhold sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor or his/her office. I hereby further consent to a lien being filed on my case by said doctor or his/her office against any and all proceeds of my settlement, judgement, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated.

I agree to never rescind this document and that any attempted rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney shall honor this Contractual Guarantee of Payment for Health Care Services as inherent in the settlement and enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to said doctor or his office for all health care bills submitted by him/her for services rendered me. Further, this agreement is made solely for said doctor's additional protection and in consideration of his forbearance on payment. I understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover damages. **Also, I understand that my responsibility to pay Wolf Chiropractic Center PS., Inc's bill is dependent and separate from Wolf Chiropractic Center PS., Inc's right to file a lien to protect its financial interest under RCW 60.44.**

I specifically request my attorney to acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctors interest, the doctor will not await payment, but will require me to make payments on a current basis.

______________________ ______________________________

Date Signature of Patient

______________________ ______________________________

Patients Driver's License Number Patient's Social Security Number

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, judgement, or verdict as may be necessary to adequately protect said doctor named above.

______________________ ______________________________

Date Signature of Attorney

Please date, sign, and return one original to ______________________________. Thank you

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION

("Agreement")

I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payers"), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past or future ("condition"), to pay directly to, and exclusively in the name of, **Wolf Chiropractic Center** or "Office", such sums as may be owing to **Wolf Chiropractic Center** for charges incurred by me including but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at **Wolf Chiropractic Center** ("charges"). I further grant a contractual lien to **Wolf Chiropractic Center** with respect to my charges, applicable to all payers; however, I understand that nothing in this Agreement shall be construed as an election by **Wolf Chiropractic Center** to claim protection under any statutory lien law. For the purposes of this Agreement, "benefits" shall include, but shall not be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purposes stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay **Wolf Chiropractic Center**, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to **Wolf Chiropractic Center** to extent of my charges, as well as any and all causes of action that I might have against such payer, to prosecute such causes of action in my name or in the Office's name, and to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office. I further direct each attorney to provide immediate notice of to the Office regarding any funds received by the attorney relating to my accident, to promptly pay such Office, and to provide a full accounting of such funds to the office upon its request.

I hereby direct all payers to release to **Wolf Chiropractic Center** any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize **Wolf Chiropractic Center** to endorse/sign my name on any and all checks listing me as a payee which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize **Wolf Chiropractic Center** to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due **Wolf Chiropractic Center** for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect any outstanding balance on my account, I will be responsible for payment and will reimburse **Wolf Chiropractic Center** for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of **Wolf Chiropractic Center** and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of **Wolf Chiropractic Center** and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Name (please print): ____

Patient Signature: ______________________________________ Date ____/____/____

Name of Custodial Parent or Legal Guardian (please print): ______________________________

Parent/Guardian' Signature: ______________________________ Date: ____/____/____

Personal Injury Insurance Questionnaire

Please Complete – ALL Information Is Required

YOUR Insurance Information **Date of Accident:** ____________

Insurance Company: ____________

Street Address: ____________

City, State, Zip: ____________

Claims Adjuster: ____________ Phone Number: ____________

Policy Number: ____________ Claim Number: ____________

Do you have PIP (personal injury protection)? ☐ Yes ☐ No

Limit? ☐ $10,000 ☐ $35,000 ☐ Not Sure ☐ Other ____________

Were you the insured? ☐ Yes ☐ No

If no, Insured's Name: ____________ Phone Number: ____________

Insured's Address: ____________

AT FAULT PARTIES Personal Information – (if other driver was fault, please complete this section)

At Fault Driver's Name: ____________

Street Address: ____________

City, State, Zip: ____________

AT FAULT PARTIES Insurance Information

Insurance Company: ____________

Street Address: ____________

City, State, Zip: ____________

Claims Adjuster: ____________ Phone Number: ____________

Policy Number: ____________ Claim Number: ____________

ATTORNEY INFORMATION **Have you retained an Attorney?** ☐ Yes ☐ No

Firm / Attorney Name: ____________

Phone Number: ____________

Street Address: ____________

City, State, Zip: ____________

Personal Injury Policy
(Motor Vehicle Accidents)

We will accept you as a personal injury patient based on our clinical examination and determination that chiropractic care will be an effective treatment for your injuries.

Your responsibility to this office will be to follow the treatment plan the Doctor establishes for you and to provide us with the appropriate information so that services can be billed and payment can be received by this office for the services we provide.

Regarding Payment of fees for patients with PIP (Personal Injury Protection) Claims:

We will bill your automobile insurance carrier directly for payment under your PIP policy and assist you in every way we can for reimbursement. At some point in your treatment, it is common practice for your own insurance company to request an IME (Independent Medical Exam) with *their* doctor. NOTIFY US IMMEDIATELY when this happens! Most often this doctor determines that you no longer need ongoing care even if your injuries have not yet resolved and your carrier will stop paying for your treatment. At that time, our office is then forced to wait until your claim is settled for further payment. This can take several months to several years, depending upon your individual case. If this happens, please see our policy below for Third Party patients.

Regarding Payment of fee for patients with Third Party Claims:

It is our policy to allow you to defer payment of the doctor's fees until any and all possible insurance benefits are paid or until your case is settled, provided that the following conditions are satisfied:

1. You are represented by an attorney specializing in personal injury cases;
2. That the merits of your case are established by your attorney and communicated to us;
3. That you follow the doctors treatment plan;
4. That you pay a $35 co-pay for massage treatments at the time of service;
   AND
5. That you reveal all possible insurance coverages available and sign all required paperwork to affect payment of your doctor's fees at the earliest possible time.

Additionally

6. We will file a medical lien which is recorded in King or Pierce County Court to protect our right to be paid;
7. And you agree to pay 5% of the unpaid balance per month until the balance is paid in full if the claim extends one (1) year beyond your release of care from our facility.
8. A finance charge will be assessed each month on the unpaid balance.

I understand and agree to the above policies.

_______________________________ SIGNATURE   _______________ DATE