Buckeye Chiropractic and Wellness
Synergy Medical
16705 Square Drive Marysville, Ohio 43040

Patient Name______________________________ DOB: ______________ ☐ Male ☐ Female

Check appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

SS #/SIN______________________

Email: ______________________Home phone______________ Cell Phone ______________

Patient's Address ______________________City ____________ State______ Zip__________

Employer Name: ____

Spouse or Patient's Guardian name____________________ Spouse's Employer________________

How did you hear about us? ____

Person to contact in case of an emergency______________________________ Phone______________

Responsible Party

Name of The Person responsible for this account ____________________Relationship to Patient ______________

Is the person currently a patient at our office? ☐ Yes ☐ No

E-Mail ______________________Home Phone ______________Cell Phone ______________

Address ______________________City______________State______Zip__________

Driver's License # ______________________ Date of Birth: ____________

Do you have any Medical insurance? ☐ Yes ☐ No if yes, complete the following:

Name of the insured______________________________ Relationship to patient______________

Birthdate____________ SS#/SIN______________________ Work Phone ______________

Name of Employer____

Employer Address ______________________City ____________ State ________ Zip__________

Insurance Company______________________ Group #______________ Union or local # ______________

Ins. Co. Address ______________________ City ____________ State ________ Zip __________

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

______________________________________ ______________________

Parent or Guardian Date

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Buckeye Chiropractic and Wellness/Synergy Medical** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that **have been or will be** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this __________ day of ________________, 20 ______. X______________________________ *(SEAL)*

(Patient signature)

X______________________________ *(SEAL)* X______________________________

(Signature of Guardian if applicable) *(Please print patient name)*

Health History

Chief Complaint: ____

History of Present illness:

Location: ______________________
(Where is the pain/problem?)

Quality: ______________________
(Example: normal vs abnormal color, activity, etc..)

Severity: ______________________
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: ______________________
(How long have you had this pain/ problem? When did it start?)

Timing: ______________________
(Does the pain/problem occur at a specific time?)

Context: ______________________
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms ______________________
(What other associated problems have you been having?)

Modifying Factors ______________________
(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

Have you ever had the following: (Please check all that apply)

- □ Anemia
- □ Bladder Infection
- □ Epilepsy
- □ Whooping Cough
- □ Scarlet Fever
- □ Diphtheria
- □ Small pox
- □ Pneumonia
- □ Rheumatic Fever
- □ Arthritis
- □ Venereal Disease
- □ Stroke Chronic Bronchitis
- □ Infectious Mono AIDS & HIV
- □ Back Trouble
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Migraine Headaches
- □ Tuberculosis
- □ Diabetes
- □ Cancer
- □ Polio
- □ Glaucoma
- □ Hernia
- □ Mitral Valve Prolepses
- □ Hepatitis
- □ Ulcer
- □ Kidney Disease
- □ Hemorrhoids
- □ Bleeding Tendency
- □ Asthma
- □ Hives or Eczema

Date of Last Chest X-Ray____________

Any Other Disease, *(Please List):*

____

____

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State

Medication: *(include nonprescription)*

____

____

Sleep:

Average length of sleep *(hours)*:__________

Does pain affect sleep? NO YES

How many pillows do you sleep with? 1 2 3 4

Energy level: Low Moderate Adequate

How has your mood been lately? ______________________________

Patient Social History:

Marital Status	Single: ______	Married: ______	Separated: _______	Divorced: _______	Widowed: _______
Use of Alcohol	Never: ______	Rarely: _______	Moderate: _______	Daily: ________	
Use of Tobacco	Never: ______	Rarely: _______	Moderate: _______	Daily: _________	
Use of Drugs	Never: ______	Type/Frequency: ______________________			
Excessive Exposure					
At home or at work to:	Fumes: ______	Dust: ______	Solvents: ______	Airborne Particles: ______	Noise: _______

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father			
Mother			
Sibling's			
Spouse			
Children			

Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Itching	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain b/t shoulder blades	1 2 3 4 5
Muscle Spasm	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Pins/needles in hands/feet	1 2 3 4 5
Recent Vision Changes	1 2 3 4 5
Loss of Consciousness	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling foggy	1 2 3 4 5
Forgetfulness	1 2 3 4 5
Insomnia/difficult sleeping	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_______________________________ *Signature of the Patient, Parent or Guardian*

_______________ *Date*

Provider's Review

_______________________________ *Signature of Provider*

_______________ *Date*

BUCKEYE CHIROPRACTIC & WELLNESS
SYNERGY MEDICAL
CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature____ Date _________________

Witness Signature ____ Date_________________

Female Only

_____ I am NOT pregnant.

_____ I am pregnant.

Buckeye Chiropractic & Wellness/Synergy Medical
16705 Square Dr. Marysville, OH 43040
(937)642-4400 (p) ~ (937)642-4443 (f)

Protecting Your Health Information

New Regulation Passed

This new regulation is part of the Health Insurance Portability and Accountability Act or HIPPA and does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individuals and medical records.

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed protecting it. We create a record of the care and services you receive at our office. We need the record to provide you with the quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes every attempt to maintain the confidentiality of all patients' information.

Disclosure of Medical Information

In addition to disclosing your medical information for treatment, payment and health care operations, we may disclose medical information for the following purpose: for a court order, subpoena, discovery request or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are the victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or similar issues.

If someone calls or comes by, they will not be given any information about your care and/or appointments unless otherwise specified and noted in your file.

We will also be publicly noting your name in our newsletter and/or picture in our lobby unless otherwise specified. Upon becoming a patient, we will be entering your name and email into our database and you may receive our monthly newsletter. If you do not wish to receive our newsletters, please contact our office and advise the receptionist of such. This list will not be sold to any outside agencies.

Your Rights

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

Open Adjusting Concept

Because of the open adjusting concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may include anything concerning the primary health care of that patient.

Notification by Mail or Phone

Patients may be contacted by mail, email, or phone unless written notification is requested that contact be only in person.

Complaints

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department of Health and Human Services.

Patient/Guardian Signature:____Date:_______________

GUARANTEE OF MEDICAL AND/OR HEALTH BILLS FROM SPECIFIC CLAIM FUNDS AND FIRST PARTY ASSIGNMENT

This Assignment, made effective on the ________ day of ____________________, 20______, by and between _______________________________ ("Patient") and Buckeye Chiropractic & Wellness/Synergy Medical, and its officers, agents, members, shareholders, subsidiaries, assigns, employees, and directors (collectively referred to as "Clinic");

Witnesseth:

WHEREAS, _________________________ insurance company insures Patient through a contractual right of uninsured/underinsured-motorist coverage and/or medical-payment coverage and/or health-insurance coverage and/or any other contractual right between Patient and insurance company ("First Party Insurance");

WHEREAS, Patient was involved in an accident on or about ______________________________ in which he/she was injured and for which he/she has a claim against another person(s) and/or liability insurance carrier(s) (including, but not limited to, "First Party Insurance" or "Third Party Insurance") for causing his/her injuries and/or damages (hereinafter referred to as "Claim");

WHEREAS, to the best of Patient's knowledge, the person(s) who caused the Claim is/are insured by ___________________________ insurance company(ies);

WHEREAS, Patient is entering into this Assignment and Guarantee of Payment voluntarily and without duress;

WHEREAS, Patient acknowledges that he/she has the right and opportunity to seek independent legal counsel to review this Assignment prior to execution; ________________ (Patient's initials)

WHEREAS, Patient seeks to have the Clinic provide medical care, treatment, and services as a result of Patient's Claim;

WHEREAS, Clinic agrees to provide medical care, treatment, and services to Patient for the injuries Patient sustained in the accident referred to above; and,

WHEREAS, Patient and Clinic desire to enter into this Assignment and Guarantee of Payment in accordance with the terms contained herein.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, and for other good and valuable consideration, the receipt of which is hereby acknowledged, it is agreed as follows:

1. **Patient hereby personally GUARANTEES payment of the Clinic's fees incurred by Patient to the Clinic for all treatment and other services rendered by the Clinic arising out of the Claim and/or from any proceeds and/or specific funds from Patient's Claim, including, but not limited to, third-party settlement(s), judgment(s), or verdict(s), and/or any first-party benefits, including but not limited to med-pay or other contractual proceeds. Patient affirms that this guarantee constitutes a lawful interest pursuant to Ohio Rule of Professional Conduct 1.15(D).**

I have read and agree to the above guarantee to claim funds: ______________________________
(Signature of Patient) (Date)

2. **Patient hereby ASSIGNS, without any right to later revoke, a part of any proceeds from his/her Claim equal to the fees incurred by Patient to the Clinic for all treatment and other services rendered by the Clinic. Patient is not assigning any legal cause of action in the Claim above, but only contractual proceeds. Patient also assigns to the Clinic his/her right to enforce the obligation of any insurance company to pay med pay or other contractual proceeds for any treatment Patient receives in exchange for this assignment of first-party insurance benefits, including med-pay benefits. Prior to settlement or other disposition of the Claim, Patient understands and permits Clinic to pursue payment from any insurance company that insures Patient through a contractual right of uninsured/underinsured-motorist coverage and/or medical-payment coverage and/or health-insurance coverage and/or any other contractual right between Patient and insurance company, including medical-payments coverage in an automobile liability policy. Patient also assigns, without any right to later revoke, a part of any available medical-payments coverage equal to fees incurred by Patient to Clinic for all treatment and other services rendered by Clinic.**

I have read and agree to the above assignment of claim funds: ______________________________
(Signature of Patient) (Date)

3. **Patient directs the First Party Insurance Company to include the Clinic's name on all first party insurance contractual draft and/or check payments, including med pay payments. Further, Patient directs the First Party Insurance Company, including medical-payments carrier, to send all med pay payments to the Clinic at 16705 Square Drive Marysville, Ohio 43040. Further, Patient authorizes and permits First Party Insurance Company, including Patient's applicable med-pay insurance, to disclose to Clinic the terms and amount of insurance proceeds available, including applicable med-pay coverage, under the subject first party insurance contractual policy.**

4. This Assignment and Guarantee and related documents, which Patient has signed in connection with it, state the entire agreement and Patient's complete understanding regarding the Clinic's fees. Patient has not relied on any statements by the Clinic or other information before making this Assignment. Patient understands that he/she remains responsible to Clinic for any Clinic fees not paid out of Patient's First Party Insurance Claim(s).

5. Patient understands that it is Patient's responsibility during treatment to remain aware of his/her cumulative account balance for services rendered. Patient has received a schedule of treatment fees for the Clinic; if Patient has not received a schedule of treatment fees prior to signing this Assignment and Guarantee of Payments, Patient agrees to immediately request one in writing.

6. Patient understands that this is an express contract to pay for the services rendered by the Clinic. Patient agrees to pay his/her account balance in full and/or direct its payment from the Claim proceeds. If Patient disputes his/her account balance or treatment rendered, Patient agrees that his/her remedy will be to resolve the dispute with a separate action from the Claim.

NOTICE: PATIENT HEREBY NOTIFIES AND DIRECTS ANY AND ALL FIRST PARTY INSURANCE COMPANIES, THIRD-PARTY ADMINISTRATORS, ATTORNEYS, OTHER PERSONS, AND/OR OTHER ENTITIES WHO HOLD OR LATER MAY HOLD ANY PROCEEDS FROM PATIENT'S CLAIM THAT CLINIC NOW HAS A LAWFUL INTEREST (AS THAT TERM IS USED AND APPLIED IN RULE 1.15(d) OF THE OHIO RULES OF ATTORNEY PROFESSIONAL CONDUCT) IN SAID PROCEEDS BY WAY OF THIS WRITTEN AGREEMENT GUARANTEEING PAYMENT FROM THE SPECIFIC FUNDS DESCRIBED ABOVE, AND PATIENT HEREBY DIRECTS YOU TO PROMPTLY DELIVER AND PAY THE CLINIC THE MONIES COLLECTED FROM THE FIRST-PARTY INSURANCE AND/OR THIRD PARTY SETTLEMENT(S), JUDGMENT(S), AND/OR VERDICT(S),

EQUAL TO THE FEES INCURRED BY THE PATIENT FOR CARE AND TREATMENT, UNLESS THE CLINIC EXPRESSLY CONFIRMS PRIOR PAYMENT OF IT IN WRITING.

7. Ohio law governs this Assignment. Jurisdiction shall be in Ohio, and venue shall lie in the county, which the Clinic is located, unless otherwise required by applicable law. As a result of this Assignment and Guarantee of Payment from the specific funds and/or property referenced above, Rule 1.15 of the Ohio Rules of Professional Conduct applies to any and all funds held by the Patient's attorney related to Patient's Claim. If any of the provisions of this Assignment and/or Guarantee of Payment from the specific funds and/or property referenced above are deemed not binding by a court of competent jurisdiction, then it is agreed that the other remaining provisions of this entire agreement shall be construe as legal, valid, and/or enforceable.

8. Patient authorizes the Patient's applicable attorney to issue a letter of protection to the Clinic in order to protect the Clinic's outstanding professional bills that remain unpaid after payments are received from the Patient's First Party Insurance Carrier and/or from any third-party settlement(s), judgment(s), or verdict(s) as additional consideration for the services provided by the Clinic and/or for the Clinic delaying collections of the services owed by the Patient.

9. **PATIENT ACKNOWLEDGES AND UNDERSTANDS THAT HE/SHE HAS NOW GIVEN AWAY A PART OF ANY PROCEEDS FROM HIS/HER CLAIM FOR WHICH THE CLINIC NOW HAS A LAWFUL INTEREST. IF PATIENT RECEIVES ANY PROCEEDS FROM HIS/HER CLAIM UNDER THIS ASSIGNMENT, PATIENT AGREES TO IMMEDIATELY DETERMINE IF THE CLINIC HAS BEEN SEPARATELY PAID IN FULL. UNLESS THE CLINIC EXPRESSLY CONFIRMS FULL PAYMENT IN WRITING, PATIENT ACKNOWLEDGES AND UNDERSTANDS THAT ANY USE BY PATIENT OF THESE PROCEEDS CONSTITUTES A TAKING OR CONVERTING MONEY THAT IS THE PROPERTY OF THE CLINIC.**

10. EVEN THOUGH THE CLINIC FIRST REQUESTED THAT PATIENT IS ONLY PERSONALLY GUARANTEEING PAYMENT FROM SPECIFIC FUNDS FROM THE PATIENT'S CLAIM, PATIENT FURTHER AGREES, NOTWITHSTANDING ANY CLAIM PAYMENTS, PATIENT UNEQUIVOCALLY **PERSONALLY GUARANTEES** PAYMENT TO CLINIC REGARDLESS OF THE OUTCOME OF ANY LEGAL ACTION, CLAIM, AND/OR FINAL DETERMINATION. PATIENT INSTRUCTS AND/OR WILL INSTRUCT HIS/HER ATTORNEY AND/OR INSURANCE COMPANY TO RELEASE ANY AND ALL INSURANCE FUNDS TO FULFILL PATIENT'S OBLIGATIONS TO THE CLINIC.

____
Signature of Patient *Date*

IN WITNESS WHEREOF, the parties hereto have caused this Assignment and Guarantee of Payment from the specific funds described above to be executed and effective as of the date first written above.

PATIENT	**Buckeye Chiropractic & Wellness/Synergy Medical**
Signed: ____________________	____________________
Print Name: ____________________	By: ____________________
Signature of Parent/Legal Guardian:	Title: ____________________
____________________	Date: ____________________
Date: ____________________	

Payment For Treatment and Related Expenses

I have been injured. If my automobile insurance has medical payments coverage, I authorize this Clinic to bill this insurer and I will submit a claim with my insurer for this Clinic's treatment fees. 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 (including under or uninsured motorists coverage proceeds) must be immediately paid over to this Clinic.

If I believe that one or more persons are at 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 authorize 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 understand that the Clinic may require any recipient of such information to comply with applicable federal, state, and/or local law prior to and during receipt of such information.

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)

IMPORTANT ACKNOWLEDGEMENT BY PATIENT WHO HAS SIGNED A PERSONAL INJURY PROCEEDS ASSIGNMENT

______ Patient Initials

I understand this Assignment, and how it will affect my prospective settlement proceeds. I know that the Clinic is starting treatment in reliance that I understand the Assignment. I received a copy of the Assignment.

______ Patient Initials

I understand that I cannot cancel or terminate the Assignment, and will not permit any attorney for me to attempt to do this.

______ Patient Initials

I understand that this Clinic is entitled to its treatment fees first out of any and all settlement proceeds.

______ Patient Initials

If I believe the prospective settlement from an insurance company will not be enough to cover my damages and this Clinic's treatment fees, I realize that I will owe any balance to this Clinic for my treatment. I can choose to continue treatment, or can consult with my chiropractic physician at this Clinic about decreasing or terminating treatment prior to reaching Maximum Medical Improvement.

______ Patient Initials

I state that I am not currently a debtor in a pending Chapter 7 or Chapter 13 Bankruptcy Proceeding.

______ Patient Initials

I understand that this Assignment and the related documents that I have signed are for the purpose of protecting the Clinic's rights, and that they are not intended or designed to provide legal assistance to or for me.

Automobile Accident Questionnaire

Name____

Date of accident_______________ **Today's Date**_______________

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
___Left ___Middle ___Right ___Front Passenger ___Rear Passenger
___Third Seat (rear) ___Other (please specify_____________________)

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 □ Stop Sign
□ Pedestrian □ Traffic □ Busy Intersection

COLLISION TYPE:

□ Driver Side Impact □ Head-on Collision □ Front Impact
□ Passenger Side Impact □ Rear 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 COMPROMISED BY:

□ Brightness □ Darkness □ Fog
□ Rain □ Snow □ Traffic

The following questions concern the moment of impact of the accident:

WERE YOU...
- □ Unaware that the accident was impending
- □ Aware that the accident was impending
- □ Aware that the accident was impending and braced for it

RESTRAINTS:
- □ Seat belt
- □ Shoulder harness
- □ No restraints

If were the driver of the vehicle, was your foot on the brake pedal?

□ Yes □No □ Knocked off by impact

WAS THE AIR BAG DEPLOYED?

□ Car not equipped with airbag □ Air bag deployed □ Air bag not deployed

WHAT POSITION WAS YOUR HEADREST IN?

□ High position □ Middle position □ Low position

POSITION OF YOUR HEAD AT IMPACT?

□ Facing straight ahead □ Tilted forward
□ Rotated to the left □ Rotated to the right

WAS YOUR HEAD THROWN?

□ Backward and then forward □ Forward and then backward
□ To the left □ To the right
□ To the left, then the right □ To the right, then the left

POSITION OF YOUR BODY AT TIME OF IMPACT:

□ Straight □ Tilted forward □ Rotated to the left □ Rotated to the right

WAS YOUR BODY THROWN?

□ Backward and then forward □ Forward and then backward □ To the left
□ To the left then the right □ To the right then the left □ To the right
□ Across the vehicle □ Outside of the vehicle
□ Under the vehicle

DAMAGE TO THE VEHICLE YOU WERE IN:

- ☐ Incurred minimal damage
- ☐ Incurred severe damage
- ☐ Incurred moderate damage
- ☐ Was totaled
- ☐ Not known

CITATIONS:

- ☐ None issued
- ☐ Yourself
- ☐ Driver of vehicle in which you were passenger
- ☐ 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
- ☐ Gearshift
- ☐ Front seat
- ☐ Backseat

LEFT ARM:

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

RIGHT ARM:

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

TORSO:

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

LEFT LEG:

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

RIGHT LEG:

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

The following questions concern the time period immediately following the accident:

DID YOU LOSE CONSCIOUSNESS?

- ☐ 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 □ Was driven home □ Drove to work
□ Was driven to work □ Drove to hospital □ Was driven to hospital
□ Drove to school □ Was driven to school □ Taken to hospital by 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	

SIGNATURE: ____

Rachel G. Frinak, MS APRN FNP-C Charita N. Cooper, DC CACCP Patrick S. Cooper, DC CCEP

When it comes to your health, chiropractors and medical doctors should be working together for your benefit!

I agree! I give you permission to inform my primary care physician of my condition, treatment and expected/actual response to care at this office.

Patient/Guardian Signature: ______________________________

Name (Please Print): ______________________________

Primary Care Physician: ______________________________

Physician's Address/Phone: ______________________________

____

16705 Square Drive

Marysville, OH 43040

P. 937.642.4400 F. 937.642.4443

SynergyMedicalTeam.com