DYER CHIROPRACTIC CLINIC
Motor Vehicle Collision Questionnaire

Patient Name:_____ Date:_____

Address:_____ City:_____ State:____ Zip Code:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
Email Address: _____
Sex: M F Marital Status: M S D W Date of Birth:_____ Age:_____
Social Security #:_____
Occupation:_____ Employer:_____
Employer Adress:_____
Spouse Information:
Name: _____ Birth Date:___/___/___ SSN____-____-____
Phone:_____ Occupation:_____ Employer:_____

Emergency Contact: Name:_____ Phone Number:_____

Have you ever received Chiropractic Care? Yes No If yes, when?_____

Past Chiropractor (name, address, phone number):_____

1. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):_____
_____
_____

2. Since the Motor Vehicle Collision, have you experienced any of the following:

A. Loss of Range of Motion: yes/no

a. What body parts:_____

B. Visual Disturbance : yes/no (please explain):_____

C. Dizziness: yes/no How often:_____

D. Anxiety: yes/no How often:_____

E. Depression: yes/no How often:_____

F. Difficulty Sleeping: yes/no How often:_____

3. Past Health History:

A. Please indicate if you have a history of any of the following:

☐Anticoagulant use ☐ Heart problems/high blood pressure/chest pain ☐Bleeding problems
☐Lung problems/shortness of breath ☐ Cancer ☐Diabetes ☐ Psychiatric disorders
☐Bipolar disorder ☐ Major depression ☐ Schizophrenia ☐Stroke/TIA's
☐None of the above ☐ Other _____

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B. Previous Injury or Trauma: _____

-Have you ever broken any bones? Which?_____

_____

C. Allergies:_____

D. Medications:

Medication: Reason for taking:

_____
_____
_____
_____
_____

E. Surgeries:

Date: Type of Surgery:

_____
_____
_____
_____
_____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery: Outcome:

_____
_____
_____
_____
_____

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

☐ Cancer ☐ Strokes/TIA's ☐ Headaches ☐ Cardiac disease ☐ Neurological diseases
☐ Adopted/Unknown ☐ Cardiac disease below age 40 ☐ Psychiatric disease
☐ Diabetes ☐ Other _____ ☐ None of the above

5. Social and Occupational History:

A. Job description:

_____

B. Work schedule:

_____

C. Recreational activities:

_____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

_____

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DYER CHIROPRACTIC CLINIC
Motor Vehicle Collision Questionnaire

Review of Systems

Have you had any of the following pulmonary (lung-related) issues?

☐ Asthma/difficulty breathing ☐ COPD ☐Emphysema ☐Other _____ ☐None of the above

Have you had any of the following cardiovascular (heart-related) issues or procedures?

☐ Heart surgeries ☐ Congestive heart failure ☐Murmurs or valvular disease ☐Heart attacks/MIs ☐ Hypertension
☐ Heart disease/problems ☐ Pacemaker ☐Angina/chest pain ☐ Irregular heartbeat ☐ Other _____
☐ None of the above

Have you had any of the following neurological (nerve-related) issues?

☐ Visual changes/loss of vision ☐ One-sided weakness of face or body ☐ History of seizures
☐ One-sided decreased feeling in the face or body ☐ Headaches ☐ Memory loss ☐ Tremors ☐ Vertigo
☐ Loss of sense of smell Strokes/TIAs ☐ Other _____ ☐ None of the above

Have you had any of the following endocrine (glandular/hormonal) related issues or procedures?

☐ Thyroid disease ☐ Hormone replacement therapy ☐Injectable steroid replacements ☐Diabetes
☐ Other _____ ☐ None of the above

Have you had any of the following renal (kidney-related) issues or procedures?

☐Renal calculi/stones ☐Hematuria (blood in the urine) ☐Incontinence (can't control) ☐Bladder Infections
☐Difficulty urinating ☐Kidney disease ☐ Dialysis ☐ Other _____ ☐None of the above

Have you had any of the following gastroenterological (stomach-related) issues?

☐ Nausea ☐Difficulty swallowing ☐Ulcerative disease ☐Frequent abdominal pain ☐ Hiatal hernia ☐ Constipation
☐ Pancreatic disease ☐Irritable bowel/colitis ☐ Hepatitis or liver disease ☐ Bloody or black tarry stools
☐ Vomiting blood ☐Bowel incontinence ☐Gastroesophageal reflux/heartburn ☐Other _____
☐ None of the above

Have you had any of the following hematological (blood-related) issues?

Anemia Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) HIV positive Abnormal bleeding/bruising Sickle-cell anemia Enlarged lymph nodes Hemophilia Hypercoagulation or deep venous thrombosis/history of blood clots Anticoagulant therapy Regular aspirin use Other _____ None of the above

Have you had any of the following dermatological (skin-related) issues?

Significant burns Significant rashes Skin grafts Psoriatic disorders Other _____ None of the above

Have you had any of the following musculoskeletal (bone/muscle-related) issues?

Rheumatoid arthritis Gout Osteoarthritis Broken bones Spinal fracture Spinal surgery Joint surgery Arthritis (unknown type) Scoliosis Metal implants Other _____ None of the above

Have you had any of the following psychological issues?

Psychiatric diagnosis Depression Suicidal ideations Bipolar disorder Homicidal ideations Schizophrenia Psychiatric hospitalizations Other _____ None of the above

Is there anything else in your past medical history that you feel is important to your care here?

_____

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____

Signature of Patient of Representative Date

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DYER CHIROPRACTIC CLINIC
Motor Vehicle Collision Questionnaire

Patient Name: _____ Date:_____

Practitioner: Sid L. Dyer, D.C.

Symptom 1:_____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin?_____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin?_____
- What makes the symptom worse? (circle one)
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):_____
- What makes the symptom better: (circle all that apply)
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe):_____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, other (please describe):_____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate?_____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2:_____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin?_____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin?_____
- What makes the symptom worse? (circle one)
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):_____
- What makes the symptom better: (circle all that apply)
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe):_____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, other (please describe):_____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate?_____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

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Symptom 3:_____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin?_____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin?_____
- What makes the symptom worse? (circle one)
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):_____
- What makes the symptom better: (circle all that apply)
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe):_____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, other (please describe):_____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate?_____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 4:_____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin?_____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin?_____
- What makes the symptom worse? (circle one)
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):_____
- What makes the symptom better: (circle all that apply)
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe):_____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, other (please describe):_____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate?_____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

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Symptom 5:_____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin?_____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin?_____
- What makes the symptom worse? (circle one)
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):_____
- What makes the symptom better: (circle all that apply)
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe):_____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, other (please describe):_____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate?_____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 6:_____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin?_____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin?_____
- What makes the symptom worse? (circle one)
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):_____
- What makes the symptom better: (circle all that apply)
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe):_____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, other (please describe):_____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate?_____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

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Auto Accident Mechanism of Injury Form

Date of Collision: _____ Hour of Accident: _____AM / PM

Please describe how the collision happened:

_____

_____

_____

_____

What was your position in the car? (Circle) **Driver** / **Front Passenger** / **Left Rear** / **Right Rear**

If "Driver", were your hands on the steering wheel? **Both** / **Left** / **Right**

Did the airbags deploy? **Yes** / **No**

Did you strike another vehicle? **Yes** / **No** Did another vehicle strike your vehicle? **Yes** / **No**

Angle of Impact: **Front** / **Back** / **Left** / **Right** / **Other**: _____

If Second Collision – Angle of 2nd impact: **Front** / **Back** / **Left** / **Right** / **Other**: _____

In relation to the back of your head, was your headrest set: **Low** / **Middle** / **High**

Were you surprised by the impact? **Yes** / **No**

If "NO", how did you brace? **With Hands** / **With Feet**

Where was your head facing at the time of impact? **Straight Ahead** / **Left** / **Right** / **Behind**

Were you leaning forward at the time of impact? **Yes** / **No**

What type and year of vehicle were you in? _____

What was the approximate speed of your vehicle when the accident occurred? _____mph

What type and year of vehicle struck yours?_____

What was the approximate speed of the other vehicle when the accident occurred? _____mph

Were you wearing a seatbelt? **Yes** / **No** What type: **Lap Belt** / **Shoulder Belt** / **Both**

Did you feel pain immediately after the accident? **Yes** / **No**

Were you rendered unconscious as a result of the accident? **Yes / N**

Did you strike anything in the vehicle at the time of impact? **Yes** / **No** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

□ Steering Wheel	□ Windshield
□ Dashboard	□ Roof
□ Left Side Door	□ Right Side Door
□ Left Window	□ Right Window
□ Other	

Did your seat break or bend? **Yes** / **No**

Immediately following the accident, how did you feel? (Circle all that apply) **Dizzy** / **Dazed** / **Weak** / **Upset** / **Disoriented** / **Nervous** / **Nauseous** / **Other**: _____

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DYER CHIROPRACTIC CLINIC
Motor Vehicle Collision Questionnaire

Police and Ambulance:

Was the accident reported to the police? **Yes** / **No**

Were traffic citations issued? **Yes** / **No** If "YES", to whom? _____

Did you go to the hospital? **Yes** / **No** If "YES", when? _____

If "YES", how did you get there? **Ambulance** / **Police Car** / **Private Transportation**

Were you admitted? **Yes** / **No** If "YES", how long? _____

Name of Hospital? _____ Attended by Dr. _____

What treatment given? (Circle all that apply) **None** / **X-rays** / **Pain Medication** / **Stitches /**
Muscle Relaxants / **Bandaged** / **Cervical Collar** / **Physical Therapy** / **Instructed Regarding Concussion** / **Instructed Regarding Sprains & Strains** / **Instructed to Call an Orthopedist** / **Instructed to Call a Private Physician** / **Referred to This Office** / **Other**: _____

What other doctor have you seen as a result of this injury? _____

Do you have difficulty in excessive: **Standing** / **Walking** / **Riding** / **Bending** / **Twisting**

Do you have difficulty in excessive lifting: **Light** / **Moderate** / **Heavy** / **Repetitive**

Symptoms other than above:

_____

_____

_____

_____

_____ _____
Patient Signature Date

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Duties Under Duress Summary

Complete the following summary as it relates to your living and work duties and how the injury(s) are affecting your performance. List the day to day living duties which are painful or difficult for you to perform as a result of the injuries you sustained in the motor vehicle collision. Include those duties/responsibilities which require that you reduce the time you are capable of performing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your performance.

Job Description: _____

Work	**Reason for the difficulty**	**Duration**
Lifting	Increased Pain	_____
Bending	Increased Pain	_____
Sitting	Increased Pain	_____
Walking	Increased Pain	_____
Computer duties	Increased Pain	_____
Other: _____	Increased Pain	_____

Studies/School	**Reason for the difficulty**	**Duration**
Lifting	Increased Pain	_____
Bending	Increased Pain	_____
Sitting	Increased Pain	_____
Walking	Increased Pain	_____
Computer duties	Increased Pain	_____
Studying	Increased Pain	_____
Other: _____	Increased Pain	_____

Domestic Duties	**Reason for the difficulty**	**Duration**
Vacuuming	Increased Pain	_____
Taking care of kids	Increased Anxiety	_____
Cleaning	Increased Pain	_____
Preparing meals	Increased Pain	_____
Other: _____	Increased Pain	_____

Household Duties	**Reason for the difficulty**	**Duration**
Yard work	Increased Pain	_____
Transportation	Increased Anxiety	_____
Shopping	Increased Pain	_____
Taking out trash	Increased Pain	_____
Other: _____	Increased Pain	_____

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Loss of Enjoyment Summary

Complete the following summary as it relates to your lifestyle, work environment and activities which you normally would be enjoying, but are currently not enjoying, as a result of the motor vehicle collision. Include all areas which you have had to reduce the time you are capable of experiencing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your participation in any of the following areas:

Work	**Reason for the difficulty**	**Duration**
Lifting	Increased Pain	_____
Bending	Increased Pain	_____
Sitting	Increased Pain	_____
Walking	Increased Pain	_____
Computer duties	Increased Pain	_____
Other: _____	Increased Pain	_____

Studies/School	**Reason for the difficulty**	**Duration**
Lifting	Increased Pain	_____
Bending	Increased Pain	_____
Sitting	Increased Pain	_____
Walking	Increased Pain	_____
Computer duties	Increased Pain	_____
Studying	Increased Pain	_____
Other: _____	Increased Pain	_____

Domestic Duties	**Reason for the difficulty**	**Duration**
Vacuuming	Increased Pain	_____
Taking care of kids	Increased Anxiety	_____
Cleaning	Increased Pain	_____
Preparing meals	Increased Pain	_____
Other: _____	Increased Pain	_____

Household Duties	**Reason for the difficulty**	**Duration**
Yard work	Increased Pain	_____
Transportation	Increased Anxiety	_____
Shopping	Increased Pain	_____
Taking out trash	Increased Pain	_____
Other: _____	Increased Pain	_____

Sports	**Reason for the difficulty**	**Duration**
Social	_____	_____
Competitive	_____	_____
Regional	_____	_____
Other:	_____	_____

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Please list any and all doctors seen in the last year - two years.

Doctor: _____
Address: _____ (**if known**)
Phone: _____

Reason for visit / treatment:

_____
_____
_____

Doctor: _____
Address: _____ (**if known**)
Phone: _____

Reason for visit / treatment:

_____
_____
_____

Doctor: _____
Address: _____ (**if known**)
Phone: _____

Reason for visit / treatment:

_____
_____
_____

Doctor: _____
Address: _____ (**if known**)
Phone: _____

Reason for visit / treatment:

_____
_____
_____

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DYER CHIROPRACTIC CLINIC

33 EAST COUNTY LINE ROAD STE. A, GREENWOOD, IN 46143

Phone (317) 882-4922 **Fax** (317)882-4898

PATIENT REQUEST FOR RECORDS

DATE: _____

TO: _____

ADDRESS: _____

CITY: _____ **STATE**: _____**ZIP**: _____

I hereby authorize the release of:

_____ All Medical records
_____ X-rays
_____ Blood work results
_____ MRI results
_____ Other _____
_____

_____ Please **MAIL** records to**:** ___ **Dyer Chiropractic Clinic**
33 East County Line Rd
or **Greenwood, In 46143**

_____ Please **FAX** records to: ___ **FAX: 317-882-4898**

*Please fill out only this section and leave above blank:

Patient's Printed Name: _____

Birthdate: _____ Social Security Number: _____

Patient's Signature: _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

I hereby instruct and direct the _____

Insurance Company to pay by check made out and mailed directly to:

DYER CHIROPRACTIC CLINIC P.C.
33 East County Line Road Ste. A
Greenwood, In 46143

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it to:

33 East County Line Road Ste. A
Greenwood, Indiana 46143

The professional or chiropractic expense benefits allowed and otherwise payable to me under my current insurance policy will be used as payment toward the total charges for professional services I have received.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any Insurance company, adjuster, or attorney involved in this case.

Dated this _____day of _____, 20_____.

_____ _____

Signature of policyholder Signature of Claimant, if other than Policyholder

Dyer Chiropractic Clinic 33 East County Line Road Ste. A Greenwood, IN 46143
Phone: 317-882-4922 Fax: 317-882-4898

DYER CHIROPRACTIC CLINIC
Motor Vehicle Collision Questionnaire

Date:_____

Patient:_____

Claim#_____

To Whom It May Concern:

This letter is to authorize release of information to Dyer Chiropractic Clinic regarding my Auto Insurance policy including my Med Pay Benefits.

Thank you,

Printed Name_____

Signature_____

Dyer Chiropractic Clinic 33 East County Line Road Ste. A Greenwood, IN 46143
Phone: 317-882-4922 Fax: 317-882-4898

DYER CHIROPRACTIC CLINIC
Motor Vehicle Collision Questionnaire

PROVIDER/PATIENT ATTORNEY CLAIM AGREEMENT AND LIEN

This agreement is entered into among Dyer Chiropractic (hereinafter "Provider") and _____ _____hereinafter "Patient"), and mutual obligations set forth herein and establishes their responsibilities to each other during the pendency of Patient's claim arising from Patient's accident of _____, 20____, (hereinafter "Claim").

1. Patient hereby gives a lien to Provider against all proceeds derived from this Claim (whether by settlement, judgment, or otherwise to secure payment of all fees owed to Provider by Patient for treatment arising out of injuries sustained as of the time such proceeds are received. Patient hereby directs Attorney to honor said lien and to pay such sums as are secured thereby directly to Provider, as soon as possible after any proceeds are received.

2. Patient hereby expressly recognizes that even though this lien has been given, Patient still remains personally responsible for Provider's fees and that payment of them must be made by Patient regardless of whether any money is received through this Claim.

3. Patient hereby authorizes Provider to provide Attorney, at reasonable intervals upon Attorney's request, with complete reports of Patient's medical condition, care and cost of treatment. Provider agrees to furnish these reports within reasonable time, and at a reasonable cost.

4. Attorney hereby agrees that Attorney is a party to this contract and further recognizes that Attorney is receiving a benefit from this agreement and therefore there is a valid consideration and Attorney is thereby bound by the terms agreed to in this contract.

5. Patient agrees to direct and require all legal counsel to execute another copy of this Claim Agreement and Lien, when one is furnished by Provider.

6. Attorney and patient; hereby agree to notify Provider immediately should Patient retain new legal counsel.

7. Patient hereby instructs that in the event another attorney is substituted in this matter, the new attorney will honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

8. Attorney and Patient hereby agrees to not rescind this document and that any attempt to do so will not be honored by Attorney.

9. Attorney agrees to notify Provider of any settlement or other disposition of the claim within 10 days thereafter. Before Attorney distributes any monies received through this Claim, Attorney agrees to make a request and Provider agrees to provide a response in regard to the Patient's outstanding account balance.

10. Should any party to this agreement seek judicial enforcement of it, the party prevailing in such lawsuit shall be entitled to reasonable attorney's fees.

_____	_____	_____	_____
Patient's Signature	Date	Attorney Signature	Date
_____	_____	_____	_____
Printed Name	Date	Printed Name	Date
_____	_____	Firm Name&	_____
Witness Signature	Date	Address	_____
			_____

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