AUTOMOBILE ACCIDENT HISTORY

Accident History:

Date of Accident: _____ Time of Accident: _____ A.M. P.M.

State how the Accident happened in your own words:

_____

_____

_____

Were you driving? **Yes No** Was it your car? **Yes No** If not, whose? _____

Passenger? **Front Back Right Side Left Side** Were you rotated in seat? **Yes No**

Were you reclined? **Yes No** Other: _____

Other people in car? **Yes No**

Names and Addresses:

_____

_____

_____

Were they injured? **Yes No**

If yes, please explain: _____

Did you have your seat belts on? **Yes No** Shoulder harness on? **Yes No**

How fast were you going? _____

If there was another vehicle involved, how fast was that vehicle going? _____

What was the posted speed limit? _____

Was it? **Daylight Night Dark Dawn** What were the weather conditions? _____

How long had you been in the car? _____ What were you doing prior to the accident? _____

What were the traffic conditions? _____

Type of road: **2 Lane 4 Lane Gravel Tar**

Did it happen at a/an: **Stop Sign Traffic Light Intersection Highway**

Vehicle Information:

What type of vehicle were you in? Make: _____Model:_____Year: _____

Was your car hit? **Front Back Left Side Right Side**

What other types of vehicles were involved? Make:_____Model:_____Year: _____

Did your vehicle strike anything else? **Yes No**

If yes: **Another Car Sign Tree Other:** _____

Did your vehicle go off the road? **Yes No**

Was accident report made? **Yes No** Police of: **City: _____ County: _____ State: _____**

Who was ticketed? _____ For what? _____

State anything else that happened during or immediately after the Accident:

_____

_____

_____

Physical Health:

Did you hit part of your body during the collision, for example: head on dash, chest on steering wheel? **Yes No**

If yes, which part and how?

_____

Where were you taken after the accident? _____

Were you hospitalized? **Yes No** If yes, for how long? _____

Were you completely conscious after the impact? **Yes No** Do you remember the impact? **Yes No**

The above information is accurate and has been completed to the best of my knowledge:

Patient Signature: _____ Date: _____

ACCT#_____ PATIENT INFORMATION PG. 1

THE FOLLOWING INFORMATION IS NEEDED IN ORDER TO BETTER SERVE YOU. PLEASE ANSWER ALL QUESTIONS COMPLETELY AND ACCURATELY. PLEASE PRINT.

Full Name_____ Sex: M F

Home Phone_____ Cell Phone _____ Work Phone _____

Address_____ City_____ State_____ Zip Code_____

Age_____ Birth Date_____ Marital Status (Circle One) S M W D Sep Number of Children_____

SSN#_____-_____-_____ Driver's License Number_____

Email Address _____

Employer_____ Occupation _____ Number of Years _____

Employer Address_____ City_____ State_____ Zip Code_____

Name of Spouse/Subscriber _____Spouse/Subscriber Date of Birth: _____

Do you have Health Insurance? Yes___ No___ Are you the subscriber? Yes ___ No ___

Insurance Company_____ Subscriber ID#_____ Plan/Group #_____

In Case of Emergency:

Name of Spouse, Parent, or Guardian_____

Spouse's Employer_____ Spouse's Work Phone_____

Employer's Address_____ City _____ State_____ Zip Code_____

How did you find out about our office? _____

Is your condition today due to an accident? Yes___ No___ Date of Accident_____

I (We) agree to pay for services rendered to the above mentioned patient as the charge is occurred. I (We) understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I (We) also understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I (We) authorize the doctor and his staff to release any information deemed appropriated concerning my physical condition to any ins. Co. attorney, or adjustor in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequence thereof. I agree that a Photostatic copy of this agreement shall serve as the original.

I (We) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a Photostatic copy of this agreement shall serve as the original.

Patient Signature_____Date_____

Spouse or Guardian Signature_____Date_____

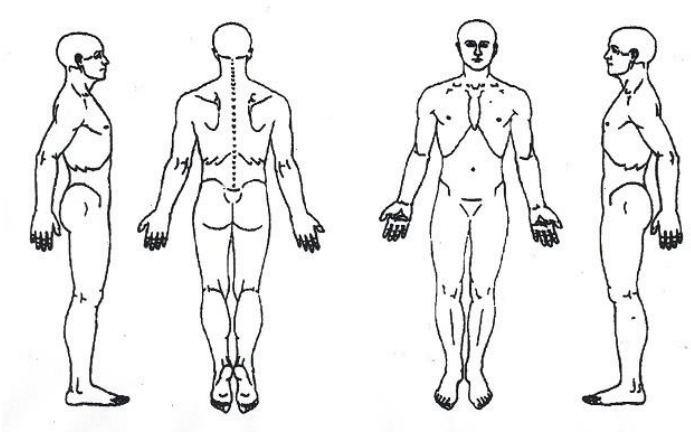
1. Notice to our new patients: Full payment for services rendered is due at the end of each visit.
2. Insurance cases: We gladly accept insurance assignment if your insurance co. a) verifies the deductible has been met, b) provides details of your coverage, and c) agrees to make payment directly to our office.
3. We file your primary ins. at no charge to you. Filings for policies in addition to you primary coverage for a fee and as time permits.

THANK YOU!

Name_____ Age_____ Sex: M F Date_____

What brings you into our office today? (Please Explain)_____

DETAILS OF THE CHIEF COMPLAINT:



1. Location of Symptoms, Injury, or Pain:
Using adjacent body charts, please circle all the affected areas.
Order of Appearance or Injury (Area)
1._____ 2._____ 3._____
Intensity of Pain (0= no pain, 10= worst)
1._____ 2._____ 3._____
(AMA Pain Scale: Minimal 1-3, Slight 4-6, Moderate 7-9, Emergency 10)
2. Has your pain spread or radiated anywhere? Yes__ No__
If so where?_____
3. When and how did it start?_____
_____
Date of Occurrence:_____ Date of First Visit_____
4. How would you describe your pain? (Sharp, Dull, Achy, etc.)
_____
5. How often do you experience your problem? (% of day)
__ Intermit. 0-25% __Occas. 26-50% __Frequent 51-75% __Constant 76-100%
6. What aggravates your condition? (posture, activity, etc)_____
_____
7. Is this an aggravation of an old injury? Y___ N___
Have you experienced anything similar to this in the past?_____
8. Have your symptoms changed since onset? Y___ N___
Decreased___ Increased___ Remained the same___ Come and Go___
9. Have you noticed any change in bodily functions? Y___ N___ (Please check those that apply.)

___ Balance	___ Bowel Habits	___Breathing	___Coordination
___ Coughing	___Walking	___Grip Strength	___Hearing
___ Menstrual	___Sexual	___Sleep	___Sneezing
___ Urination	___Vision	___Weakness	___Weight

10. Handedness: Right____ Left____ Ambidextrous____
11. Are there any activities that are harder to do or that you cannot do as a result of your condition?_____
_____
12. Work Status: Full Time___ Part Time___ Student___ Retired___ Disabled___ Unemployed___

13. Work/Home Disability: Y__ N__

Complete: ___Days off work

___Days unable to perform Household tasks

Partial: ___Days of job modification

___Days of decreased household tasks

14. Have you used any Store-bought or Home Remedies? Y__ N__

If so what? _____

Did they help? _____ Have you tried Ice? ___ or Heat?___

15. Are you able to find relief with certain activities, postures, time of the day, etc? Y__ N__

If so, please explain._____

16. Have you been treated by anyone else for this problem? Y__ N__

If so, please identify who and what type of therapy? _____

17. Are you currently under a doctor's care for any <u>other</u> conditions? Y__ N__ If so, please explain.

_____

18. Have you suffered any physical injuries such as falls or blows, whiplash, concussion, or head injury, lacerations, sprains, strain, dislocations, broken or cracked bones? Y__ N__

Please explain._____

19. Please list any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth):

_____Date_____

_____Date_____

_____Date_____

_____Date_____

20. Have you ever been hospitalized for any reason other than surgery? Y__ N__

21. Do you have a Pacemaker or any other Surgically Implanted Device? Y__ N__

22. Are you now or could you be pregnant? Y__ N__ Onset date of last menstrual cycle._____

23. Females, have you had menstrual problems? Y__ N__ Explain_____

Have you ever taken birth control pills? Y__ N__ If so, for how long?_____

24. Do you have any nervous system diseases and/or mental health problems? Y__ N__

_____

25. Do you have any muscle, tendon, or ligament problems? Y__ N__

26. Do you have any bone or joint diseases (ex. Bone= Osteoporosis, Joint= Arthritis)? Y__ N__

27. Do you have any gland or hormone problems? Y__ N__

28. Have you ever had cancer? Y__ N__

29. Are you losing weight without trying? Y__ N__

30. Does your pain wake you up at night? Y__ N__

31. Have you had any change in bowel or bladder habits? Y__ N__

32. Have you had a sore that does not heal? Y__ N__

33. Have you recently had any unusual bleeding or discharge? Y__ N__

34. **Medications:** Please list all medications (prescriptions and non-prescriptions) you are currently taking or take on an occasional basis:

Name of Medication	Dosage	Frequency

35. Do you have any allergies to medications? Y__ N__ If so, what? _____
36. Do you consume alcohol? Y__ N__ If so, how much? _____ How often? _____
37. Do you use drugs? Y__ N__ If so, what? _____
38. Do you currently smoke? Y__ N__ How much per day?_____ # of Years_____
    Former smoker? Y__ N __ How many years did you smoke?_____ How many years smoke free?_____
39. Please describe the postures and/or positions in which you work, as well as the type of work you do:_____

_____

_____

40. In what position do you usually sleep, and how well? _____
41. Family History-Parents still living? Y__ N__ Age(s)_____ Parents deceased? Y__N__ What age(s)?___
    Any diseases or medical conditions for any family members? If yes, please explain relationship and condition._____

_____

_____

Miscellaneous Notes_____

_____

_____

_____

_____

Doctor Notes:

_____

_____

_____

_____

_____

Name_____ Age_____ Date_____ File#_____

Have you ever (at any time) experienced any of the following?

Difficulty urinating	Y	N	Claustrophobia	Y	N
Loss of bladder control	Y	N	Spinal surgery	Y	N
Loss of bowel control	Y	N	Common cold/flu	Y	N
Temporary loss of vision, one eye	Y	N	Carotid artery surgery	Y	N
Blood in urine	Y	N	Breast reduction	Y	N

Have you ever been diagnosed with or told you have one of the following?

Detached retina	Y	N	Rheumatoid Arthritis	Y	N
Stroke	Y	N	Fractured/broken vertebra	Y	N
Slipped disc	Y	N	Bleeding disorders	Y	N
Herniated disc	Y	N	High blood pressure	Y	N
Osteoporosis	Y	N	Blood in the stool	Y	N
TIA's (pin or mini strokes)	Y	N	Cancer	Y	N
Drop attacks (collapsing)	Y	N	AIDS	Y	N
Hardening of the arteries	Y	N	Kidney disease	Y	N
Partial or complete paralysis	Y	N	Prostate disease	Y	N
Diabetes	Y	N			

In the past 14 days (2 weeks), have you experienced any of the following?

Nausea	Y	N	Vomiting	Y	N
Vertigo (spinning)	Y	N	Difficulty Walking	Y	N
Incoordination	Y	N	Numbness or other sensory change	Y	N
Loss of consciousness	Y	N	Double Vision	Y	N
Tinnitus (ringing in ears)	Y	N	Blurred Vision	Y	N
Speech problems	Y	N	Clumsiness	Y	N
Memory loss	Y	N	Personality changes	Y	N
Fever	Y	N	Recurrent headaches	Y	N
Diarrhea	Y	N	A Major Fall	Y	N
Skin rash/infection	Y	N	A Minor Fall	Y	N
Loss of strength	Y	N	An Auto accident	Y	N
Pain moving bowels	Y	N	A work injury	Y	N
Abnormal periods	Y	N	Head Trauma	Y	N

Do you *Currently* have any of the following?

Integument System

Skin rash	Y	N
Skin lesions	Y	N
Changes in skin color	Y	N
Itching (pruitus)	Y	N
Hair changes	Y	N
Nail Changes	Y	N

Endocrine System

Hormone problems	Y	N
Hot flashes	Y	N
Thyroid problems	Y	N
Hormone therapy	Y	N
Growth abnormalities	Y	N
Metabolism changes	Y	N

Digestive System

Abdominal pain	Y	N	Rectal bleeding	Y	N
Nausea	Y	N	Jaundice	Y	N
Vomiting	Y	N	Abdominal distention	Y	N
Constipation	Y	N	Cramping	Y	N
Diarrhea	Y	N	Lump/mass	Y	N

(Please continue on the next page.)

Cardiovascular System

Chest pain	Y	N	Changes in skin color	Y	N
Irregular heartbeat	Y	N	Stroke	Y	N
Shortness of breath	Y	N	Dizziness	Y	N
Fainting	Y	N	Cool hands or feet	Y	N
Fatigue	Y	N	Varicose veins	Y	N
Swelling in the legs	Y	N	Pin Stroke	Y	N

Pulmonary System

Coughing	Y	N
Sputum production	Y	N
Coughing up blood	Y	N
Shortness of breath	Y	N
Wheezing	Y	N
Blue skin (cyanosis)	Y	N
Chest Pain	Y	N

Musculoskeletal System

Stiffness	Y	N
Popping noises	Y	N
Joint pain	Y	N
Weakness	Y	N
Limitation of movement	Y	N
Extremity deformities	Y	N
Difficulty walking	Y	N

Nervous System

Partial paralysis	Y	N	Lack of coordination	Y	N
Complete paralysis	Y	N	Stroke	Y	N
Headache	Y	N	Speech abnormalities	Y	N
Loss of consciousness	Y	N	Visual disturbances	Y	N
Dizziness	Y	N	Walking disorders	Y	N
Memory loss	Y	N	Tremors	Y	N
Numbness	Y	N	Tics	Y	N
Weakness	Y	N	Sensory changes	Y	N
Mood Changes	Y	N			

Genital/Urinary System

Pain on urination	Y	N
Changes in urine flow	Y	N
Lump or mass in groin	Y	N
Kidney stones	Y	N
Chronic bladder infections	Y	N
Genital itching	Y	N
Changes in urination	Y	N

Special Senses

Visual problems	Y	N
Hearing loss	Y	N
Loss of balance	Y	N
Loss of taste	Y	N
Loss of smell	Y	N
Loss of touch sensation	Y	N
Temporary vision loss in one eye	Y	N

Reproductive System

Male Only			Female Only		
Testicular pain	Y	N	Abnormal vaginal bleeding	Y	N
Prostate problems	Y	N	Painful menstruation	Y	N
Infertility	Y	N	Breast lump/mass	Y	N
Impotence	Y	N	Vaginal discharge/itching	Y	N
Discharge	Y	N	Nipple discharge	Y	N
Lump or mass	Y	N	Infertility	Y	N
Male pattern baldness	Y	N	Abnormal periods	Y	N

Head and Neck Region

Headaches	Y	N	Ringing in ears	Y	N
Neck Stiffness	Y	N	Ear pain	Y	N
Neck/lump mass	Y	N	Ear discharge	Y	N
Eye pain	Y	N	Ear itching	Y	N
Eye discharge	Y	N	Nasal discharge	Y	N
Double vision	Y	N	Sinus trouble	Y	N
Dry eyes	Y	N	Bad breath	Y	N
Excessive tearing	Y	N	Nasal obstruction	Y	N
Spinning sensation	Y	N	Snoring	Y	N

Loveland Chiropractic Consent to Treat

215 Loveland- Madeira Road Loveland, OH 45140 513-683-1052

Informed Consent

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document, so please ask us if you have any questions.

The nature of the chiropractic adjustment: The primary treatment used by Doctors of Chiropractic is spinal manipulative therapy. We will use that procedure to treat you. We may utilize hands-on or mechanical instrument manipulations to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement. Common benefits of the above treatment include improved mobility and reduced pain.

Analysis/ Examination/ Treatment:

As a part of the analysis, examination, and treatment, you are consenting to the following procedures as they are recommended for you: spinal manipulative therapy, palpation, vital signs, orthopedic and basic neurological testing, range of motion, muscle strength testing, postural analysis, ultrasound, hot/cold therapy, radiographic studies, electrical muscle stimulation, dry needling (piercing the skin with fine-gauge needles), spinal decompression therapy (traction), rehabilitation stretching and strengthening, nutritional analysis/therapy, massage therapy, muscle therapy, and other treatments and tests as deemed necessary.

The material risks inherent in chiropractic treatment:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation (CMT) and therapy. These complications include but are not limited to fractures, disc injuries, dislocations, muscle strains, cervical myelopathy, pneumothorax, bruising, burns, and infection or blood-borne illness. Some types of manipulation of the neck have been associated with injuries to the arteries of the neck leading to or contributing to serious complications including stroke. Chiropractic is a safe and comfortable form of health care for most people. If a potential risk is identified, you will be informed and offered either treatment or a referral to the appropriate health care specialist for evaluation and care. If you have a condition that would otherwise not come to the doctor's attention it is your responsibility to inform the doctor.

The probability of those risks occurring:

Fractures caused from spinal manipulation are extremely rare. Patients suffering from bone weakening conditions like osteoporosis are in a higher risk category. Alternative forms of spinal manipulation may be utilized for these patients. **Please inform the doctor if you have a bone weakening disease.** Researchers have found no evidence of excess risk of VBA stroke associated with chiropractic care compared to primary care. However, if there is a causal relationship between manipulation and stroke, it is rare and remote. **Please inform us of any personal or family history of stroke.** There have been some reports of herniated or ruptured discs caused by spinal manipulation or mechanical traction. In rare circumstances dry needling has been reported to cause pneumothorax and infection. We practice evidence-based manipulation procedures and follow guidelines for all therapies to minimize risk. The risk of all other complications (material risks) mentioned above are rare, but it is not uncommon to experience minor soreness following the initial treatments.

The availability and nature of other treatment options:

One of the most common treatment options for the conditions we treat is self-administered, over-the-counter medications such as NSAIDs. Spinal manipulation is significantly safer than NSAIDS when comparing risk of adverse events. Prescription oral medications, injections, and surgical interventions are other treatment options that commonly carry significant risk.

The risks and dangers of conditions remaining untreated or undertreated:
Early intervention to restore normal function and compliance with the treatment plan are both essential in an effort to prevent conditions from progressing to a further chronic pain/symptom state.

Consent to Treat a Minor (Required for all patients under 18 years old)

I hereby request and authorize this clinic to perform diagnostic tests and render treatment to my minor (son/daughter/other) _____. This authorization extends to all doctors and staff members and includes radiographic examination at the doctor's discretion. As of this date, I have the legal right to select and authorize health care services for the minor named above. Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or parent is not required. If my authority to select and authorize this care should be revoked or modified in any way I will immediately notify this office. I also consent to the minor listed above to be treated without me present in the office.

ALL PATIENTS:

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read [ ] or have had read to me [ ] the above explanation of the examination and treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the benefits, risks, and alternatives, I hereby give my consent to all examination, testing, and treatment described above.

Patients Name: _____ Doctors Name: _Dr. Jeffrey Kemmet, DC__

Signature: _____ Signature: _____

Dated: _____ Dated: _____

Signature of Parent or Guardian (if the patient is a minor) _____

LOVELAND CHIROPRACTIC OFFICE, INC.
215 Loveland Madeira Rd. Loveland, OH 45140
(513) 683-1052

OFFICE POLICY LETTER

IN ORDER TO CONTROL OUR COST OF BILLING, WE REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and other pay percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, Medicaid and other health plans to: Loveland Chiropractic Offices, Inc., 215 Loveland Madeira Rd, Loveland, OH 45140.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

To the extent necessary to determine liability for payment, and to obtain reimbursement, I authorize disclosure of portions of any medical records.

In the event that full payment for charges incurred connection with my medical care is not made, I agree to pay all costs of collection, including reasonable attorney's fees. I also agree to submit myself to the jurisdiction of the courts of Hamilton, Ohio.

This agreement will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original.

Signed _____ **Date _____**

(RESPONSIBLE PARTY)

DESIGNATION OF AUTHORIZATION REPRESENTATIVE

I, _____, do hereby designate Jeffrey T. Kemmet, D.C. and Loveland Chiropractic Offices, Inc. (hereafter referred to "my doctor"), to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of services I receive from the above named doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies, all in connection with medical or other health care expense(s) as the result of the services I receive from my doctor.

Signed _____ **Date_____**

Loveland Chiropractic Offices
215 Loveland-Madeira Rd.
Loveland, OH 45140
(513) 683-1052

Acknowledgement of Receipt of Notice of Privacy Practices
This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice**.**

I acknowledge that I received and had the opportunity to review the Notice of Privacy Practices on the date below on behalf of Loveland Chiropractic Offices.

I understand that the Notices describes the uses and disclosures of my protected health information by Loveland Chiropractic Offices and informs me of my rights with respect to my protected health information. Please indicate other people (a spouse, significant other, or relative) you will allow this clinic to share aspects of your treatment and protected health information (including your medical information, billing information and/or scheduled appointments). You may choose to allow none.

Authorization to Release Information

1._____	**_____**	**_____**
Name	**Relationship**	**Phone**
2. _____	**_____**	**_____**
Name	**Relationship**	**Phone**
3. _____	**_____**	**_____**
Name	**Relationship**	**Phone**

Please indicate if you allow this clinic to leave information about your medical information, billing, and scheduled appointments (protected health information) in a voicemail or email as needed. Please initial each that you allow. You may choose to allow none.

Text: Y/N (appointment reminders) Voicemail? Y/ N _____(initial) **E-mail? Y / N _____**(initial)

Phone Number: _____ Email Address: _____

_____ _____
Patient's Signature or that of Legal Representative Printed Name of Patient or that of Legal Representative

_____ _____
Today's Date If Legal representative, Indicate Relationship

Explanation of Payment

I have been injured. I do not have health insurance or I do not want my health insurance company to pay for my bills from this office. I want a combination of MedPay and the At Fault Insurance company to pay my bills. **Please complete the following information for your automobile insurance as well as the at-fault automobile insurance company.**

- MedPay: MedPay (Medical Payments) is coverage that you have paid for through your own auto insurance through your policy. It covers medical bills up to your coverage limit for you, your family, and others who were in the vehicle with you when the accident occurred, regardless of who is at fault. This is the preferred method of payment and is guaranteed not to raise your insurance premiums. In order for your MedPay to pay for your claims, you must file a claim with your auto insurance company. They may pay your claims partially or in full until your limit is met between all of your doctors that you have seen under your case, depending on what they allow. We will bill your MedPay as the primary insurance company.

  Your Auto Insurance Carrier: _____

  Policy Number: _____

  Claim Number: _____

  Adjuster's Name (if known): _____

- At-Fault Insurance: This is the auto insurance of the vehicle or driver that was at fault in the accident. In order for the at-fault insurance company to pay for your claims, you must file a claim with the at fault insurance company. They may pay the remaining portion of your medical bills related to the accident, and they may wait until you have been released from our office to begin the settlement process.

  At-Fault Insurance Carrier: _____

  Policy Number: _____

  Claim Number: _____

  Adjuster's Name (if known): _____

- Have you retained an attorney? Yes/No

  Attorney's Name and Number: _____

I understand that my automobile insurer, or an insurer representing someone I believe to be at fault for causing my injuries, or that person's attorney, or an attorney representing me in a claim for my injuries, may re quest reports, copies of records, may require a physician from this clinic to provide deposition testimony in court, or other information. I understand and agree that I am financially responsible to this clinic to pay for Clinic's costs for these items; and that the clinic may request payment in advance for some or all of these items, even in 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 involved with my claim and their respective representatives. I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND IT. THIS DOCUMENT IS MADE A PART OF THE ASSIGNMENT. I HAVE SIGNED IN FAVOR OF THIS CLINIC. I HAVE RECEIVED A COPY OF THIS DOCUMENT IF I REQUESTED IT.

_____ _____

Signature of Patient Today's Date

_____

Print Patient Name

_____

Signature of Parent or Legal Guardian

Loveland Chiropractic Office
215 Loveland-Madeira Rd.
Loveland, OH 45140
Phone: (513) 683-1052
Fax: (513) 683-6226

Boehm, Kurts & Lowry, Attorneys at Law

ASSIGNMENT

I was involved in an accident on or around _____ (date) in which I was injured for which I have a claim against another person(s) for causing my injuries, including _____(name of person at fault), who is insured by _____ (name of at fault insurance company). (Referenced as "My Claim")

In consideration of the agreement of LOVELAND CHIROPRACTIC OFFICE, INC., (reference as the "Clinic") to delay billing me personally for medical treatment rendered until the resolution of My Claim.:

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

   Signature of Patient _____

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

I HAVE READ AND FULLY UNDERSTAND THE ENTIRE DOCUMENT.

Patient Signature: _____ Date: _____

Print or Type Name: _____ Staff Witness: _____

Signature of Parent or Legal Guardian: _____

HEALTH REPORT AND DOCTOR'S LIEN

To: Attorney/Insurance Adjuster
_____
_____
_____
_____

Loveland Chiropractic Office
215 Loveland-Madeira Rd.
Loveland, OH 45140
(513) 683-1052
Doctor(s): Dr. Jeffrey T. Kemmet, DC

I hereby authorize the above office to furnish you, my attorney and/or insurance company, with a full report of the doctor's examination diagnosis, treatment, prognosis, etc., of myself in regards to the Worker's Compensation Injury/Motor Vehicle Accident on _____ in which I was involved.

I hereby also authorize and direct you to withhold from any settlement, judgement or verdict such sums as are adequate to pay the above office the amounts that are due and owed the office for professional services rendered to me, both by reason of the injury on the above dates, and by reason of any other expenses that are due to the office, and to pay such sums directly to said office immediately after your receipt thereof.

I hereby further give my lien on my case to the said office against any and all proceeds to any settlement, judgement, or verdict that may be paid to you or to myself as a result of injuries for which the office has rendered me services in connection with the accident on the above date.

I fully understand and agree that I am ultimately responsible to said office for all professional bills submitted by the office for services rendered to me, and that this agreement is made solely for the office's additional protection in consideration of its awaiting payment of such bills. I further fully understand that such payment in full is not contingent on settlement, judgement or verdict by which I may eventually recover sufficient monies.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Signature of Witness Date

The undersigned, being the attorney of record for all the above patient/client, does hereby agree to observe all of the above instructions.

_____ _____
Signature of Attorney/Insurance Adjuster Date

Dear Attorney/Insurance Adjuster; Please sign, date, and return this document to the office at your earliest convenience. Thank you; your consideration is greatly appreciated!

Yours Very Truly; Loveland Chiropractic Office, Inc.

Primary Care Physician (PCP)
Name and Address Form

Patient Name: _____

PCP Name: _____

PCP Address: _____

_____

_____

PCP Phone: _____

PCP Fax: _____

----------OFFICE USE ONLY----------

Entered in computer on: _____ (date)

Initial: _____