S. G. RABE, D. C. & ASSOCIATES, INC.

3075 WEST ELM STREET
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Phone 419-224-5678
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AUTO / PERSONAL INJURY PAPERWORK

The following pages are questions that help us with the processing of your paperwork for the insurance companies and the billing. Please fill out all of the following pages with the information regarding the accident. If you have any questions regarding the Medical Pay, please contact Sherry or talk to one of the doctors.

Thank you for taking the time to help us process your paperwork.

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name:_____ Today's Date:_____

Date of Accident:_____ State Where Accident Occurred:_____

How did the accident occur? Auto _____ Fall_____ Other _____ Were you on the job? _____

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						

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 ❑Drove to work
❑Was driven home ❑Was driven to work
❑Drove to hospital ❑Drove to school
❑Was driven to hospital ❑Was driven to school
❑Taken to hospital via ambulance

Next day discomfort...?
❑increased ❑decreased ❑same

Did your major complaints exist before the accident?
❑Yes ❑ No

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						
❑Muscle Spasms						

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					

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						

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head

❑Steering wheel	❑Right door
❑Dashboard	❑Left window
❑Windshield	❑Right window
❑Armrest	❑Console
❑Headrest	❑Gear shift
❑Rear view mirror	❑Front seat
❑Left door	❑Back seat

Left Arm

❑Steering wheel	❑Right door
❑Dashboard	❑Left window
❑Windshield	❑Right window
❑Armrest	❑Console
❑Headrest	❑Gear shift
❑Rear view mirror	❑Front seat
❑Left door	❑Back seat

Right Arm

❑Steering wheel	❑Right door
❑Dashboard	❑Left window
❑Windshield	❑Right window
❑Armrest	❑Console
❑Headrest	❑Gear shift
❑Rear view mirror	❑Front seat
❑Left door	❑Back seat

Torso

❑Steering wheel	❑Right door
❑Dashboard	❑Left window
❑Windshield	❑Right window
❑Armrest	❑Console
❑Headrest	❑Gear shift
❑Rear view mirror	❑Front seat
❑Left door	❑Back seat

Left Leg

❑Steering wheel	❑Right door
❑Dashboard	❑Left window
❑Windshield	❑Right window
❑Armrest	❑Console
❑Headrest	❑Gear shift
❑Rear view mirror	❑Front seat
❑Left door	❑Back seat

Right Leg

❑Steering wheel	❑Right door
❑Dashboard	❑Left window
❑Windshield	❑Right window
❑Armrest	❑Console
❑Headrest	❑Gear shift
❑Rear view mirror	❑Front seat
❑Left door	❑Back seat

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 -------- Location-------- ❑Left ❑Middle ❑Right

❑Other _____ ❑Front Passenger ❑Rear Passenger ❑Third Seat (rear)

Speed of your vehicle:

❑Stopped	❑Moving Moderately
❑Parked	❑Moving Fast
❑Slowing	❑Moving at approx. ____MPH
❑Moving Slowly	

Why Vehicle was slowed or stopped:

❑Traffic Signal	❑Parking
❑Pedestrian	❑Traffic
❑Stop Sign	❑Busy Intersection

Collision Type:

❑Driver Side Impact	❑Head On Collision
❑Passenger Side Impact	❑Rear Impact
❑Front Impact	❑Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:
- ❑Car ❑Pickup
- ❑Van ❑Truck
- ❑Station Wagon
- ❑Other_____

Vehicle size:
- ❑Subcompact ❑Full-size
- ❑Compact ❑Mini
- ❑Bus ❑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
- ❑Rain
- ❑Snow
- ❑Fog
- ❑Traffic

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...
- ❑Totally unaware that the accident was impending
- ❑Aware that the accident was impending
- ❑Aware that the accident was impending and braced for it

Restraints: (check all that apply)
- ❑Seat belt
- ❑Shoulder harness
- ❑No restraints

If you 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 air bag
- ❑Air bag deployed
- ❑Air bag not deployed

What position was YOUR headrest in?
- ❑High position
- ❑Middle position
- ❑ Low position

Position of YOUR head at time of impact?
- ❑Facing straight ahead
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Was your head thrown...?
- ❑Backward and then forward
- ❑Forward then backward
- ❑To the left ❑To the left then the right
- ❑To 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 then backward
- ❑To the left ❑To the left then the right
- ❑To the right ❑To the right, then the left
- ❑Across the vehicle
- ❑Outside the vehicle ❑Under the vehicle

Damage to vehicle YOU were in:
- ❑Incurred minimal damage
- ❑Incurred moderate damage
- ❑Incurred severe damage
- ❑Was totaled
- ❑Not known

Citations:
- ❑None issued
- ❑Yourself
- ❑Driver of vehicle patient was a passenger of
- ❑Driver of other vehicle
- ❑Not sure

I hereby state the information on this questionnaire is true and correct. I authorize S.G. Rabe, D.C. and Associates Inc. to examine, treat and do whatever is deemed necessary in accordance with the state statutes for the care and management of my condition. I hereby authorize the release of my health evaluation, examination, treatment records, billing records and my prognosis to my insurance company, third party payer, attorney or employer if applicable.

Patient's/Guardian Signature:_____

Date:_____

S. G. Rabe, D. C. & Associates, Inc.

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Lima, Ohio 45805

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PLEASE FILL OUT **ALL** OF THE FOLLOWING INFORMATION

NOTE:

We *do not* accept third party auto's, (third party is if you are not the at fault party.) We will bill through your med-pay on your auto insurance, or we can bill through your health insurance, or you can pay cash for your visits.

YOUR AUTO/PERSONAL INJURY INFORMATION

INSURANCE COMPANY, (MED PAY OR HEALTH INSURANCE): _____

PHONE NUMBER: _____ **CLAIM NUMBER:** _____

ADDRESS TO SUBMIT BILLS TO: _____

_____

ADJUSTER/LAWYER: _____

WAS THE ACCIDENT YOUR FAULT- YES or NO (circle one)

If you have any questions regarding your auto/personal injury please contact Sherry.

Thank You!

S. G. Rabe, D. C. & Associates, Inc.

3075 W. Elm St.
Lima, Ohio 45805

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MED PAY
Specific and Irrevocable
Authorization and Assignment of Benefits

To: Steven G. Rabe, D.C., Michael S. Wheeler, D.C. and Richard L. Damschroder, Jr., D.C.

1. You are authorized to release any information you deem appropriate concerning my health condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred at S. G. Rabe, D. C. & Associates, Inc.

2. I authorize and assign the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

3. I give assignment and lien against any claims against a third party whose negligence may have caused the patient's injury, up to the amount of the bill for treatment.

4. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

5. I waiver the Statute of Limitations regarding my doctor's right to recover.

Date:_____ Signed:_____

S. G. RABE, D. C. & ASSOCIATES, INC.

PERSONAL INJURY BILLING POLICY

Due to the Statute of Limitations, which vary from state to state, litigated accounts may take up to 2-3 years to get settled. Therefore we do not accept third party claims, (when you are not the at fault party). You may have retained an attorney, we will **not** bill through the attorney. We will accept Med pay, Health insurance or Self pay.

MED PAY: Med pay coverage is medical payments coverage on an auto insurance policy. This is coverage you have on your own auto insurance. This coverage will pay for reasonable expenses incurred for necessary medical treatment because of bodily injury caused by an accident and sustained by an insured. Your insurance company pays for your visits with no deductible or co-pays to you. Your auto company will seek reimbursement from the at fault party when your claim is settled. If you need treatment after the med pay is exhausted we will bill your health insurance or you can be self-pay for each visit. You will need to contact your auto insurance company to see if med pay benefits are available, they will assign you a claim number and advise you as to where we are to submit claims.

HEALTH INSURANCE: We will bill your health insurance for your injuries. You are responsible for making your co-pay and or deductible payments at each visit. If you do not have your co-pay we will reschedule your appointment. If you have not met your deductible you will need to make payments at each visit until this is met.

SELF PAY: If you choose this option we require you to pay for each date of service in full the day you are here. We will provide a receipt for you to turn in to the third party auto or your attorney. If you do not have payment on the day of your visit we will reschedule your appointment.

The undersigned acknowledges that they were given the S. G. Rabe, D. C. & Associates, Inc. Personal Injury Billing Policy. Furthermore, I understand that they do not accept third party auto claims.

Date: _____ Patient: _____