Explanation of Payment

I have been injured. I do not have health insurance or do not want my health insurance to pay for my bills from this office. I want a combination of MedPay and the At Fault Insurance may pay my bills.

Please complete the following information for your auto insurance as well as the at-fault auto insurance.

MedPay. MedPay (Medical Payments) is coverage that you have paid for through your own auto insurance. It covers medical bills up to your coverage limit for you, your family and others riding in your vehicle in case of an accident, regardless of who is at fault. This is the preferred method of payment and is guaranteed not to raise your insurance premiums.

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. This insurance may pay your medical bills related to the accident.

At-Fault Auto Insurance Carrier _____
Policy Number _____
Claim Number _____
Adjuster's Name (if known) _____

Have you retained an attorney? Yes / No
Name and Address of Attorney: _____
_____
_____

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 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 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 HAVE READ THIS DOCUMENTATION 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.**

_____ _____
(Signature of Patient) *(Date)*

_____
(Print or type patient name)

_____
(Signature of Parent or Legal Guardian)

Kauffman Chiropractic LLC
910 Loveland-Madeira Rd #4
Loveland, OH 45140
PH#: (513) 444-4529
Fax#: (513) 880-1049

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** If not, who was? _____ If you were a passenger, which seat were you in? _____
- Was it your car? **Yes No** If not, whose? _____
- Were you rotated in seat? **Yes No** Were you reclined? **Yes No**
- Were there other people in car? **Yes No** Were they injured? **Yes No** If yes, please explain:_____
- Names and Addresses:

  _____

  _____
- Were 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 Other**:_____

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 did you go 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**

I have completed this to this form truthfully and to the best of my ability. **Patient Signature: _____**

ASSIGNMENT

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

In consideration of the agreement of KAUFFMAN CHIROPRACTIC LLC, (referenced as the "Clinic") to delay billing me personally for medical treatment rendered until 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 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, will request this Clinic for one in writing.**

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 ACCOUNT BALANCE OUT OF THE TOTAL PROCEEDS HELDIN MY BEHALF, UNLESS THE CLINIC CONFIRMS PRIOR PAYMENT OF IT IN WRITING. "TOTAL PROCEEDS" HELD BY AN ATTORNEY FOR MY CLAIM 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 SEPERATLY 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 THE DOCUMENT AND I FULLY UNDERSTAND IT

_____ _____
(Signature of Patient) (Date)

_____ This Assignment Has Been
(Print or Type Name) Signed on the Clinic Premises:

_____ _____
(Signature of Parent or Legal Guardian) (Staff Witness)

HEALTH REPORT AND DOCTOR'S LIEN

To: Attorney/Insurance Adjuster
____
____
____
____

Kauffman Chiropractic LLC.
910 Loveland-Madeira Rd #4
Loveland, Ohio 45140
(513) 444-4529
Doctor(s): David Kauffman, D.C.

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

I hereby also authorize and direct you to withhold from any settlement, judgment 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, judgment, 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 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, judgment 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; Kauffman Chiropractic LLC.