

Pain Centers

7862 Kingland Drive Ste 201 *West Chester, OH 45069
Phone (513) 755-1341 * Fax (513) 755-5342

Accident Information

Name: _____

Do you have an attorney? _____

If yes:

Name: _____

Address: _____

Phone: _____ Fax: _____

If related to an auto accident

Date of Accident: _____

Your Auto Insurance Co & Number: _____

Claim #: _____

Claims adjuster name: _____

Third Party/responsible Insurance Co & Number: _____

Claim #: _____

Claims adjuster name: _____

If related to a work accident

Date of Accident: _____

Claim #: _____

Place of employment at time of injury _____

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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 person's 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)

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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.

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ASSIGNMENT

I was involved in an accident on or around _____ in which I was injured or which
[Date]
I have or may have a claim against another person(s) for causing my injuries (including _____)
[Name of Person at Fault]
(referenced as "My Claim"), who is insured by: _____
[Name of Person at Fault's Insurance Company]

In consideration of the agreement of _____ (referenced as the "Clinic") to delay billing me personally for medical services 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 to this Clinic. I am not assigning any legal cause of action in My Claim above, but only prospective proceeds. **The Clinic is not a subrogee for its charges. This Assignment does not assign My Claim itself. This Assignment assigns an interest in prospective proceeds from My Claim. Any Obligor (defined below) will be bound at the moment proceeds from My Claim exist.** Separate and apart from my own pursuit of My Claim, I will submit a claim for the Clinic's fees for medical payments coverage in my automobile liability policy, or the policy of the driver of the car in which I rode.

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 other information before making this Assignment. I understand that I remain responsible for any Clinic fees not paid out of My Claim. If I subsequently die or become totally disabled, this Assignment is binding on my estate and my personal representative(s).**

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 this 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 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 or to escrow my proceeds in the amount of my account balance.

5. **NOTICE: I DIRECT ANY INSURANCE COMPANY, ATTORNEY, OR OTHER PERSON WHO NOW HOLDS OR LATER HOLDS ANY PROCEEDS FROM MY CLAIM ("OBLIGOR") TO APPLY ANY PROCEEDS FROM MY CLAIM TO MY TOTAL ACCOUNT BALANCE OUT OF THE TOTAL PROCEEDS FOR MY CLAIM TO COMPLY, ANY OBLIGOR MAY SIMPLY INCLUDE THE CLINIC AS A JOINT PAYEE ON ALL SETTLEMENT DRAFTS ISSUED TO ME. "TOTAL PROCEEDS" HELD BY AN ATTORNEY FOR MY CLAIM SHALL MEAN PROCEEDS AFTER DEDUCTION OF ATTORNEY FEES, BUT MED PAY PROCEEDS RECEIVED OR HELD BY MY ATTORNEY SHALL NOT BE SUBJECT TO PRIOR DEDUCTION OF ATTORNEY FEES.**

6. This Assignment is governed by Ohio law. Jurisdiction shall be in Ohio, and venue shall lie in any Ohio county permitted by law.

7. **I REALIZE THAT I HAVE NOW GIVEN AWAY A PART OF THE 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 ASSIGNED PROCEEDS IS TAKING AND CONVERTING MONEY THAT IS THE PROPERTY OF THIS CLINIC.**

8. I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND IT. I RECEIVED A COPY.

(Signature of Patient)

(Date)

(Print of Type Patient Name)

This Assignment Has Been Signed on the
Clinic's Premises

(Signature of Parent of Legal Guardian)

(Staff Witness)

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Simple Agreement Form

The Patient authorizes the Doctor to deposit checks received on the Patient's account when made out to the Patient.

Signature: _____

Date: _____

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 _____)

(Name of Person at Fault)

(referenced as "My Claim"), who is insured by: _____. My insurance company/my

(Name of At Fault Insurance Company)

driver's insurance company is _____. In consideration of the agreement of

(Name of Med-Pay Insurance Company)

_____ (referenced as the "Clinic") to delay billing me personally for medical

(Name of Clinic)

services 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 to this Clinic. I am not assigning any legal cause of action in My Claim above, but only prospective proceeds. **The Clinic is not a subrogee for its charges. This Assignment does not assign or transfer any part of My Claim itself. This Assignment assigns an interest in prospective proceeds from My Claim. I will not join the Clinic or add the Clinic as a party to My Claim. I know that the Clinic is relying on this promise and will not extend this treatment unless I make this promise. I remain solely in control of the prosecution and disposition of My Claim, and nothing in this Assignment shifts any control of My Claim or any part of it to the Clinic. I am free to settle My Claim for any amount I choose, abandon it or otherwise dispose of My Claim in my sole, absolute and unfettered discretion. Any Obligor (defined below) will be bound at the moment proceeds from My Claim exist.** Separate and apart from my own pursuit of My Claim, I will submit an insurance claim for the Clinic's fees to my liability insurer or to the liability insurer for the driver of the car in which I rode. Any proceeds from this insurance claim are also "PROCEEDS FROM MY CLAIM" including or underinsured motorist coverage proceeds. This Assignment can be released in writing by the Clinic.

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 other information before making this Assignment. I understand that I remain responsible for any Clinic fees not paid out of My Claim. If I subsequently die or become totally disabled, this Assignment is binding on my estate and my personal representative(s).**

3. **I understand that it is my responsibility during treatment to remain aware of my cumulative amount balance for services rendered. I have received a schedule of treatment fees for this 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 the Clinic. This Assignment is valid and binding on me and every Obligor regardless of whether any other person or entity attempts to or fails to fully reimburse me for it, or regardless of whether the treatment is characterized by anyone as "palliative" or for "maintenance care", or "not or proximately casually related to My Claim", or as only providing comfort or pain relief, so long as I have received that treatment by the Clinic. 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 or to escrow my proceeds in the amount of my account balance.

5. **NOTICE: I DIRECT ANY INSURANCE COMPANY, ATTORNEY, OR OTHER PERSON WHO NOW HOLDS OR LATER HOLDS ANY PROCEEDS FROM MY CLAIM ("OBLIGOR") TO APPLY ANY PROCEEDS FROM MY CLAIM TO MY TOTAL ACCOUNT BALANCE OUT OF THE TOTAL PROCEEDS FOR MY CLAIM. TO COMPLY, ANY OBLIGOR MAY SIMPLY INCLUDE THE CLINIC AS A JOINT PAYEE ON ALL SETTLEMENT DRAFTS ISSUED TO ME. "TOTAL PROCEEDS" HELD BY AN ATTORNEY FOR MY CLAIM SHALL MEAN PROCEEDS AFTER DEDUCTION OF ATTORNEY FEES, BUT MED PAY PROCEEDS RECEIVED OR HELD BY MY ATTORNEY SHALL NOT BE SUBJECT TO PRIOR DEDUCTION OF ATTORNEY FEES.**

6. This Assignment is governed by Ohio law. Jurisdiction shall be in Ohio, and venue shall lie in any Ohio county permitted by law.

7. **I REALIZE THAT I HAVE NOW GIVEN AWAY A PART OF THE FUTURE 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 ASSIGNED PROCEEDS IS TAKING AND CONVERTING MONEY THAT IS THE PROPERTY OF THIS CLINIC.**

8. I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND IT. I REVIEWED A COPY.

(signature of patient)

(date)

(print or type patient name)

**This Assignment Has Been Signed On the Clinics
Premises**

(Signature of Parent of Legal Guardian)

(Staff Witness)

IMPORTANT REPRESENTATIONS AND ACKNOWLEDGEMENTS 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 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 will not add the Clinic as a Plaintiff or Defendant if I file a lawsuit for My Claim.**

Patient Initials **I understand that this Clinic is entitled to its treatment fees out of any and all settlement proceeds before any amounts are paid to me.**

Patient Initials **At any time after treatment starts, 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 physician at this Clinic about decreasing or terminating treatment.**

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.**

PATIENT VERIFICATION

I have been advised by this Clinic that the preferred method for payment of treatment fees is for the fees to be paid directly by me as I receive treatment. **COMPLETE EVERY PART OF THIS DOCUMENT:**

CHECK EVERY BOX THAT IS TRUE:

TRUE:

I do not choose to pay for treatment fees as received, for financial reasons.

TRUE:

I do not have health insurance that will cover my treatment for my injuries.

IF PATIENT HAS HEALTH INSURANCE CHECK ONE OF THE FOLLOWING BOXES:

This Clinic is not under contract as a provider for my health insurance. I do not want my health insurance to be billed for treatment of my injuries, except in the case that my own liability insurer requires it as condition to qualifying for medical payments coverage. **I have chosen to not seek and not authorize health insurance reimbursement for this Clinic's treatment fees knowingly, and after considering my alternatives. I do not want to pay health insurance co-payments and/or do not want the potential obligation to have to currently pay this Clinic for treatment which is not covered by my health insurance.**

The Clinic is under contract as a provider for my private health insurance, or I am covered by Medicare or Medicaid or other government sponsored health insurance. I authorize this Clinic to bill my health insurance for all covered services. I understand that I may be required to pay co-payments at the time of service. **I understand and agree that all services and charges of this Clinic not covered by my health insurance will be paid pursuant to the Assignment and related documents I have signed.**

The Clinic is under contract as a provider for my private health insurance, or I am covered by Medicare or Medicaid.
However, I do not want to pay health-insurance co-payments, and/or I do not want the potential obligation to have to pay this Clinic for treatment which is not covered by my health insurance, and/or I do not want to use up any of my annual visit limitations for my insurance for this treatment which has been caused by an accident. Therefore, I have chosen to not seek and not authorize health insurance reimbursement for this Clinic's treatment fees, knowingly, and after considering my alternatives. I AGREE TO NOTIFY MY PRIVATE HEALTH INSURER OF THIS WRITING IF REQUESTED BY THIS CLINIC.

I authorize this Clinic to bill my own liability (auto) insurer for treatment fees I incur, (unless required to bill my health insurer, as checked above). I authorize this Clinic to send notice of the Assignment to my own liability (auto) insurer, to the liability (auto) insurer of the person I claim caused my injuries, and to the attorney representing me for My Claim. This document is made a part of the Assignment I have signed in favor of the Clinic.

Name of Liability Insurer for Person at Fault

Name of My Liability Insurer, or My Driver's Liability Insurer

Name of My Attorney

I have received a copy of an Assignment which I have signed in favor of this Clinic and Schedule of Treatment Fees.

(Signature of Patient, Parent or Legal Guardian)

(Date)

(Print or Type Above Name)

(Staff Witness)

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 motorist coverage proceeds) must be immediately paid over 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 insurer or my driver's 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 cost 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 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 first 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 THIS 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 of Legal Guardian)