Zelm
CHIROPRACTIC CENTER, S.C.

VERY IMPORTANT
AUTOMOBILE INSURANCE INFORMATION

It is the policy of Zelm Chiropractic Center to go through your MEDICAL PAYMENTS COVERAGE UNDER YOUR AUTO POLICY. If ther was another party involved in this accident and they were to blame for this accident, your insurance company will in turn collect from the other party's insurance carrier.

CONTACT INFORMATION OF YOUR AUTOMOBILE INSURANCE CARRIER AND AGENT

CARRIER:_____

AGENT:_____

ADDRESS:_____

_____

PHONE:_____

Has this accident been reported to your automobile insurance carrier? ____ YES _____ NO

You will need to notify your insurance agent and tell them that there will be bills submitted by our office and ask them to pay out of your Medical Payments Coverage.

4861 Larson Beach Rd.
McFarland, WI 53558
Phone: 608-838-7723
Fax: 608-838-6379

Personal Injury Questionnaire

Name _____ Phone _____

Address _____City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ Social Security # _____

Were there any witnesses? Yes No Name(s) _____

Nature of Accident
Date of Accident _____ Time of Day _____

Were you: Driver Passenger Front Seat Back Seat

Number of people in your vehicle? _____ Were you all wearing seat belts? _____

What direction were you headed? North South East West

Name of Street your vehicle was on? _____

What direction was other vehicle heading? North South East West

Name of street other vehicle was on? _____

Were you struck from: Behind Front Left Side Right Side

Approximate speed of your car? _____ MPH Other car? _____ MPH

Were you knocked unconscious? Yes No If yes, for how long? _____

Were police notified? Yes No

In your own words describe accident: _____

_____

_____

Did you have any physical complaints before accident? Yes No If yes, describe in detail: _____

_____

Please describe how you felt:
During accident? _____

Immediately after accident? _____

Later that day? _____

Next day? _____

What are your present complaints and symptoms? _____

_____

Do you have any previous illnesses that relate to this problem? Yes No
If yes, describe in detail: _____

_____

Have you ever been involved in an accident before? Yes No If yes, describe, including dates/types of accidents/injuries received:_____

_____

Where were you taken after the accident? _____

Have you been treated by any other doctor since the accident? Yes No If yes, list doctor's names and address: _____

_____

If yes, what type of treatment did you receive? _____

_____

Check symptoms you have noticed since accident:

HeadacheIrritability	Numbness	Face Flushed	Cold Feet	Neck Pain	Pins & needles in arms
Chest Pain	Dizziness	Buzzing in Ears	Hands Cold	Neck Stiff	Shortness of breath
Neck stiff Fatigue	Cold Sweats	Stomach upset	Back Pain	Cold Sweats	Head seems heavy
Depression	Fainting	Nervousness	Tension	Diarrhea	Pins & needles in legs
Ears Ring Fever	Loss of memory	Loss of smell	Loss of taste		

Symptoms other than above? _____

Have you lost time from work as a result of this accident? Yes No If yes, complete the following:
Type of work: _____

Last day worked:_____
Are you being compensated for time lost from work? Yes No

Do you notice any activity restrictions as a result of this inury? Yes No If yes, describe in detail:

_____

_____

Other information: _____

_____

_____

_____ _____
(date) (signature)

Zelm Chiropractic Center, S.C.
4861 Larson Beach Rd.
McFarland, WI 53558
Phone: 608-838-7723
Fax: 608-838-6379

Auto Medical Payment Authorization

Re:
_____

D.O.B.
_____

Claim #:
_____

To whom it may concern:
This letter is to authorize you to pay Zelm Chiropractic Center billings out of the medical pay benefits of my policy. I am also authorizing you to directly pay the Zelm Chiropractic Center for any treatments which were sustained in the accident listed above.

_____ _____
(signature) (date)

INSTRUCTION TO COUNCIL

I, _____ clearly understand that all past, present and future bills incurred at Zelm Chiropractic Center are my responsibility for payment.

I hereby ratify my agreement to pay all bills incurred during my health care at this clinic.

I also hereby irrevocably agree to have the doctors entire bill paid from any proceeds of any nature by way of settlement, judgment or otherwise, I or Zelm Chiropractic Center might receive. I do hereby instruct you, _____ to pay the doctor in full
(attorney's name)
from any such proceeds of settlement, judgement, or enforcement of judgement actions. You are to pay the doctor prior to disbursing any proceeds to me. I also understand that if the settlement does not cover the doctor's entire bill, I am responsible for the remainder.

I do hereby waive any applicable statute of limitations on the collection of my account with this clinic.

I instruct you, _____, not to attempt to negotiate my doctor's bill,
(attorney's name)
who has provided all services billed for, and I agree to pay in full.

_____ _____
(signature) (date)

4861 Larson Beach Rd.
McFarland, WI 53558
Phone: 608-838-7723
Fax: 608-838-6379