Donnermeyer Chiropractic Personal Injury

First name: _____ middle: _____ Last: _____ date: _____
Home Address _____ City _____ Zip _____
Home Phone _____ Cell Phone# _____ Carrier: _____
Date Of Birth: _____ Sex: F M Email Address: _____
Date of Accident _____ Referred by: _____
Area of Pain _____ Do you Smoke? No Yes Race: _____
Preferred Language: _____ Ethnicity: circle one: Hispanic/Latino NOT Hispanic/Latino

---

Your *Auto Insurance* _____ **Other Person's** *Auto Insurance* _____
Address _____ Address _____
Phone Number _____ Phone Number _____
Claim Adjuster _____ Claim Adjuster _____
Claim Number _____ Claim Number _____

DO YOU HAVE MEDICAL COVERAGE THROUGH YOUR AUTO INSURANCE? YES NO
IF YES, WHAT IS YOUR AMOUNT AVAILABLE? $_____

Name of Your ***Health Insurance*** _____
Phone Number _____
Insured Name _____
ID Number _____ Group Number _____

Do you have an ***Attorney?*** Yes No
If Yes, Name of Attorney _____
Address _____
Phone Number _____

Briefly describe your auto accident: _____
_____
_____
_____

Were police notified? Y N
Has your auto insurance been notified? Y N
Did you lose consciousness? Y N
Were you examined after the accident? Y N If yes, where? _____
Have you had prior symptoms? Y N _____

DONNERMEYER CHIROPRACTIC – CPI

First Name _____Middle:_____ Last:_____ Date:_____
Home address:_____ apt#:_____ City:_____ State:____ Zip_____
Home phone#:_____ Cell phone#: _____Carrier_____
E-Mail address: _____ sex: M F Date of Birth:_____ age:_____
Height: _____ Weight:_____ # of children_____ Marital Status: M S W D Spouse's Name:_____
Emergency Contact _____ Phone # of Emergency Contact _____ _____
Employer: _____ Occupation: _____ Work Phone# _____

Your :_ Physician _____Referred by:_____

List the Problems you want us to address:

1. _____
2. _____
3. _____

When did the primary problem start? Approximate Date: _____
Did it come on: Instantly Over several minutes Over several hours Other _____
Briefly describe what activity you were doing: _____

_____

_____

_____

What positions or activities make it better? Lifting Sitting Standing Walking Other _____
What positions or activities make it worse? Lifting Sitting Standing Walking Other _____
Have you had problems in this area of your body before? _____ If yes, describe briefly: _____

_____

_____

_____

What other doctors, therapists, or chiropractors have you seen in the past?

_____

_____

Do you exercise regularly? (Briefly describe how often, how long, what type…)

_____

_____

Have any of the following tests been done?

Test	Approx. Date	Where was the test done?	Results
X-Rays			
MRI			
CAT Scan			
Mylegram			
EMG			
Other			

Have you had any of these treatments previously?

	Helped A Lot	Helped A Little	No Effect	Made Worse	How often do you do this?
Chiropractic Manipulation	☐	☐	☐	☐	_____
Massage	☐	☐	☐	☐	_____
Electrical Stimulation	☐	☐	☐	☐	_____
Traction	☐	☐	☐	☐	_____
Injection	☐	☐	☐	☐	_____
Other Treatments	☐	☐	☐	☐	_____

Please list prescription or over-the-counter medications you routinely take:

Name of Medication	What is it for?	Dose and Frequency	When did you start?

Have you been hospitalized or had any surgery in the past 5 years? _____ If yes, briefly describe when and what for:

_____

_____

Do any of the following diseases run in your family? (Grandparents, parents, siblings, children)

☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ Stroke ☐ Depression

Circle any/all that you have had in the last 3 months:

Accidental bowel movements
Bloody or black stools
Constipation
Diarrhea
Problems with bowel movements
Accidental urination
Burning, foul smelling, cloudy, or bloody urine
Inability to urinate
Problems with urination
Urge to urinate more frequently than usual
Chest pain or tightness
Coughing or coughing up blood
Difficulty talking or swallowing
Fevers or chills
Nausea and/or vomiting
Shortness of breath
Stomach or belly pain
Depression
Frequent headaches
Loss of vision or double vision
Difficulty sleeping
If yes, how long does it take to fall asleep? _____
How many times a night do you awaken? _____
Problems with sexual function
Unexpected weight loss of more than 10 lbs.
Difficulty walking
Leg cramps when walking or at night
Loss of balance/falling
Numbness or tingling in arms, forearms, or hands
Numbness or tingling in thighs, legs, or feet
Poor coordination
Swelling in feet or ankles
Weakness in thighs, legs, or feet
If you are female:
Is there any chance you could be pregnant now?
Yes No
Are your symptoms worsened near your period?
Yes No

Any known allergies:-List all:_____

_____

_____

Demographic: preferred Language:_____ Race:_____

Ethnicity: circle one Hispanic/Latina or NOT Hispanic/Latino Do you smoke? No. yes

Donnermeyer Chiropractic – PI INFORMATION SHEET

Attention Personal Injury Patients:

Thank you for selecting Donnermeyer Chiropractic for relief and recovery following your recent motor vehicle accident. We are committed to providing the best care and strive to exceed your expectations by preventing any financial surprises whenever possible.

Recently, the State of Wisconsin Commissioner of Insurance drafted new insurance guidelines for personal injury reimbursement. Those guidelines became law January 1, 2003. These guidelines direct how we are to be reimbursed for services rendered in the personal injury cases.

The (OCI) Office of the Commissioner of Insurance for the state of Wisconsin has set new guidelines for how HMO's handle subrogation. That means all negotiations with third party insurers for personal injuries must be handled by the health plan. In addition all providers must follow the same guidelines.

At the Time of Your First Visit, we will request a copy of your auto insurance card and your health insurance card. We will submit all claims to your auto insurance if Medical Pay is available. We will verify directly with your auto insurance company for you. When there is no Medical Pay or Medical Pay is exhausted we will send all claims directly to your health insurance in accordance with the new guidelines.

For Patients with Network Health Coverage: If you have Network Health insurance and your Medical Pay is exhausted, the new guidelines require all reimbursement by a third party or any other subrogation activities be handled by your health insurance. Your HMO health insurance will cover all charges and subrogate with the responsible party on your behalf. If your agreement with HMO requires you to make a co-pay, we will collect it at the time of service. Please contact Membership Services at your health insurance with any questions you may have relative to subrogation. All parties providing care or providing representation are bound by the new guidelines.

For Patients with Non-HMO Coverage: Once your Medical Pay is exhausted we will bill your health insurance. **Any charges not covered are your responsibility.** You may be contacted by the other driver's auto insurance. Any settlement or subrogation is an agreement between you and that company. Subrogation can take a few months or years to complete. If you choose to do this, we will ask for a $50.00 a month payment or $20.00 per visit until the time of settlement. At settlement, your balance is due in full. We can provide you with an itemized record of all charges and payments for your negotiations with the other insurer.

For Patients without Health Insurance: ALL CHARGES ARE YOUR RESPONSIBILITY. You may be contacted by the other driver's auto insurance. Any settlement or subrogation is an agreement between you and that company. Subrogation can take a few months or years to complete. If you choose to do this, we will ask for a $50.00 a month payment or $20.00 per visit until the time of settlement. At settlement, your balance is due in full. We can provide you with an itemized record of all charges and payments for your negotiations with the other insurer.

No Health Insurance and Accidents with Uninsured Motorists:
ALL CHARGES ARE YOUR RESPONSIBILITY.

Donnermeyer Chiropractic – ACCIDENT CONDITIONS

Name _____ Today's Date _____

Accident Date _____ Time of Accident _____ ☐ AM ☐ PM

Patient: ☐ Driver ☐ Passenger Vehicle Was: ☐ Moving ☐ Stopped Estimated Speed: _____ MPH

Road Condition(s): ☐ Dry ☐ Damp ☐ Wet ☐ Rain ☐ Ice ☐ Snow

Head Rest: ☐ None ☐ Integral ☐ Adjusted in Position Shoulder Harness: ☐ Wearing ☐ Not Wearing

Seat Belt: ☐ Wearing ☐ Not Wearing Head Position: ☐ Facing Forward ☐ Facing Left ☐ Facing Right

Hands Position: ☐ One on Wheel ☐ Both on Wheel Aware of Impending Collision: ☐ Yes ☐ No

Felt Body Go Forward: ☐ Forward ☐ Backward ☐ Sideways ☐ Other _____

Second Collision **IN** Vehicle: ☐ Yes ☐ No ☐ If Yes, Explain: _____

_____

Second Collision **OUTSIDE** of Vehicle: ☐ Yes ☐ No ☐ If Yes, Explain: _____

_____

Other(s) in Car: ☐ Driver_____ ☐ Passenger_____ ☐ Passenger_____ ☐ Passenger_____

Wearing Glasses: ☐ Yes ☐ No Glasses Still On After Collision: ☐ Yes ☐ No

Loss of Consciousness: ☐ Yes ☐ No

Initial Signs and Symptoms: ☐ None ☐ Headache ☐ Dizziness ☐ Disorientated ☐ Shock

☐ Numbness/Tingling in: ☐ Arms ☐ Legs ☐ Other_____

☐ Upper Back Pain/Stiffness ☐ Middle Back Pain/Stiffness ☐ Lower Back Pain/Stiffness

Onset of Signs and Symptoms: ☐ Date:_____ ☐ Sun. ☐ M ☐ Tue ☐ W ☐ Th. ☐ F ☐ Sat.

How Many Hours After the Accident:_____

After Accident I/We went: ☐ Home ☐ Hospital ☐ ASAP ☐ Later VIA: ☐ Car ☐ Ambulance

Hospital Procedures: ☐ X-Rays ☐ Laboratory Tests ☐ Collar ☐ Prescription_____

Diagnosis:_____ Instructions:_____

☐ Went To Doctor's Office Dr.'s. Name:_____ Date:_____ Time:_____ ☐ AM ☐ PM

Police Involved: ☐ Yes ☐ No Report Filed: ☐ Yes ☐ No

Brakes: ☐ On ☐ Off Transmission: ☐ Manual ☐ Automatic

Type of Car: Year_____ Make_____ Model_____

Other Car(s) Involved: Year_____ Make_____ Model_____

Year_____ Make_____ Model_____

Location of Impact: ☐ Front ☐ Back ☐ Right Side ☐ Left Side Vehicle: ☐ Driveable ☐ Not Driveable

Prior Medical Care and Doctor_____ ☐ X-Rays Date_____

Prior Chiropractic Care and Doctor_____ ☐ X-Rays Date_____

Prior Motor Vehicle injuries_____ Date_____

Prior Workers Compensation Injuries_____ Date_____

Prior Sports Injuries_____ Date_____

Please Draw the Accident Scene

DONNERMEYER CHIROPRACTIC L.L.C.

873 N Casaloma Dr Appleton, WI 54913-8606 FUNCTIONAL RATING

NAME:_____ DATE:_____Phone#:_____

In order to properly assess your condition we must understand how much your problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

0----------1----------2----------3----------4

No pain | Mild pain | Moderate Pain | Severe Pain | Worst Possible Pain

2. Sleeping

0----------1----------2----------3----------4

Perfect Sleep | Mildly Disturbed Sleep | Moderately Disturbed Sleep | Greatly Disturbed Sleep | Totally Disturbed Sleep

3. Personal Care (Washing, dressing, etc.)

0----------1----------2----------3----------4

No Pain; No Restrictions | Mild Pain; No Restrictions | Moderate Pain; Need To Go Slowly | Moderate Pain; Need Some Assistance | Severe Pain Need 100% Assist

4. Travel (driving, etc.)

0----------1----------2----------3----------4

No Pain On Long Trips | Mild Pain On Long Trips | Moderate Pain On Long Trips | Moderate Pain On short Trips | Severe Pain On Short Trips

5. Work

0----------1----------2----------3----------4

Can Do Usual Work Plus Unlimited Extra Work | Can do usual work No Extra Work | Can Do 50% Of Usual Work | Can Do 25% Of Usual Work | Can Not Work

6. Recreation

0----------1----------2----------3----------4

Can Do All Activities | Can Do Most Activities | Can Do Some Activities | Can Do A Few Activities | Can Not Do Any Activities

7. Frequency Of Pain

0----------1----------2----------3----------4

No Pain | Occasional Pain 25% Of The Day | Intermittent Pain 50% Of The Day | Frequent Pain 75% Of The Day | Constant Pain 100% Of The Day

8. Lifting

0----------1----------2----------3----------4

No Pain With Heavy Weight | Increased Pain With Heavy Weight | Increased Pain With Moderate Weight | Increased Pain With Light Weight | Increased Pain With Any Weight

9. Walking

0----------1----------2----------3----------4

No Pain Any Distance | Increased Pain After 1 Mile | Increased Pain After ½ Mile | Increased Pain After ¾ Mile | Increased Pain With All Walking

10. Standing

0----------1----------2----------3----------4

No Pain After Several Hours | Increased Pain After Several Hours | Increased Pain After 1 Hour | Increased Pain After ½ Hour | Increased Pain With Any Standing

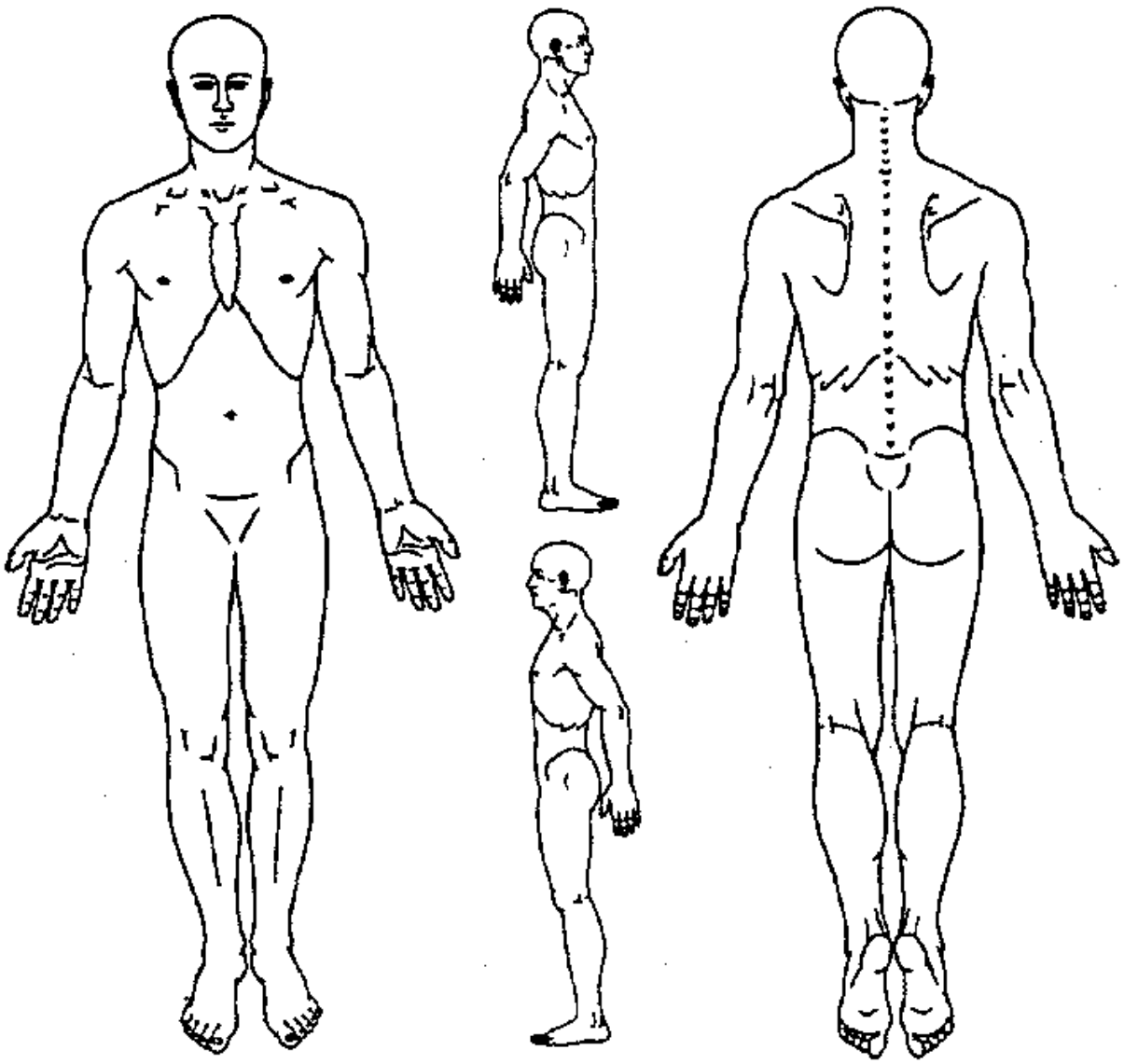
Score:_____

Name:_____ Date:_____

PAIN DIAGRAM

On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

Key: **A** – ACHE **B** – BURNING **N** – NUMBNESS
P – PINS & NEEDLES **S** – STABBING **O** - OTHER



PAIN SCALE

Rate the severity of your pain by checking one box on the following scale.

No Pain — Worst Possible Pain

0	1	2	3	4	5	6	7	8	9	10

Donnermeyer Chiropractic
873 N Casaloma Drive, Appleton ,WI 54913
920-734-2400 Phone 920-734-2100 Fax
FINANCIAL POLICY

PATIENT FINANCIAL RESPONSIBILITY – PERSONAL INJURY

I understand I am responsible for all charges not covered by insurance, including but not limited to: all claims denied, unpaid due to deductibles, co-insurance partially paid due to arbitrary determination of unusual and customary, non-covered supplies and all charges denied from a completed review for medical necessity.

I understand if my health insurance does not include coverage for chiropractic and/or physical therapy benefits, I will be required to pay at time of service. I further understand I have the right to establish a payment plan when costs exceed my ability to pay.

I understand Donnermeyer Chiropractic L.L.C. does not bill third party insurance. Any settlement or subrogation is an agreement between that company and me. Subrogation can take a few months or years to complete. Donnermeyer Chiropractic L.L.C. can provide an itemized record of all charges and payments for me to use in negotiations with the other insurer.

I, _____, on this date, _____, also hereby agree to have the doctor receive payment for the entire bill incurred at his/her office from any settlement or settlements I might receive. I will hereby instruct my lawyer or insurance company, _____, to pay the doctor before I receive any money from any settlement.

I also hereby authorize release of records pertaining to this case to my insurance company or any insurance company, and/or attorney that may be liable for my chiropractic expenses in the future.

I clearly understand that all past, present and future bills incurred at this clinic are my responsibility for payment. I also understand that if the settlement does not cover the doctor's entire bill, I am still responsible for the remainder.

I understand if I cannot make an appointment. I will call to cancel. We realize that everyone forgets once in awhile, which is why we don't charge you for the first missed appointment. However, to avoid this becoming habit, you WILL be charges $20.00 for the second missed appointment and for every one thereafter.

_____ _____
Print Name Signature

_____ _____
Witness Date

Donnermeyer Chiropractic
CONSENT FORM

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

Doctor Initials	Patient Initials	
___	___	I have been informed that it is not uncommon that patients have some increased discomfort after an adjustment. If that happens, I will apply ice to the area and rest it. If I am concerned about this discomfort or develop any new symptoms, I can call the number listed above to speak with the doc during normal business hours. If I am out of town or unable to contact the doctor, I can present myself to an emergency room or other health care facility.
___	___	If any tests were performed outside of this office (laboratory or other diagnostic procedures) I understand that the doctor will notify me of the results at my next scheduled appointment.
___	___	I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the Doctor of Chiropractic named below and/or anyone working in this clinic authorized by the Doctor of Chiropractic.
___	___	I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.
___	___	I have read the above consent, with the doctor, as indicated by our initials. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

To be completed by the patient:

Print Patient's Name	Signature of Patient (or parent/guardian)	Date Signed

Doctor's Signature:_____

Dr Brad Donnermeyer

Donnermeyer Chiropractic LLC

873 N Casaloma Drive, Appleton, WI 54913 Phone#: 920-734-2400

HIPPA Compliance Patient Consent Form

Our notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of this notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your healthcare information. YOU have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

+protected health information may be disclosed or used for treatment, payment or healthcare operations

+the practice reserves the right to change the privacy policy as allowed by law.

+The practice has the right to revoke this consent in writing at any time and all full disclosures will then cease.

+the practice may condition receipt of treatment upon execution of this consent.

May we phone, email or sent a text to you to confirm appointments? Yes No

May we leave a message on your answering machine at home or on your cell phone? Yes No

May we discuss your medical condition with any member of your family? Yes No

If yes, please name the members allowed: _____

This Consent was signed by: Please print name:_____

Signature_____date:_____

Witness: _____date: _____