Personal Injury or Automobile Collisions

If injured in a Motor Vehicle Collision or other accident in which Personal Injury Protection (PIP) is not available you have a few payment options available to you.

1. You may pay cash for your care and we will provide reports if necessary.
2. We will accept a Letter of Protection from an Attorney and await payment until the time of settlement as long as you follow recommended treatment guidelines.
3. Westenhaver Chiropractic in accordance with Washington State R.C.W. 48.80.30(5), will bill your personal health insurance plan. <u>You will be responsible for all deductibles, co-pays, and/or co-insurance fees as they are incurred</u>.
   If your health insurance benefits become exhausted before treatment(s) are concluded you may then accept one of our other payment options.
   If you prefer us not to bill your personal health insurance we will not and you can chose on of the other payment options.
   In order to bill your personal health insurance YOU will need to provide a letter from YOUR motor vehicle insurance company stating YOU DO NOT have PIP.

This agreement holds true as long as the patient is under care. If the patient interrupts care against the recommendations of the doctor(s) at Westenhaver Chiropractic, the entire balance will become due and payable at that time. The patient hereby agrees to indemnify Westenhaver Chiropractic for all expenses incurred to enforce collection of any amount due under this agreement. The patient also agrees to pay reasonable attorney's fees and court costs incurred in such collection.

________ I would like to pay cash for all care rendered.

________ I would like Westenhaver Chiropractic to await payment until settlement and will provide a Letter of Protection from my Attorney.

________ I would like Westenhaver Chiropractic to bill my personal injury insurance once this has been exhausted then please bill my health insurance.

________ I would like Westenhaver Chiropractic to bill my Health Insurance until my benefits are exhausted, I will then make other payment arrangements.

________ I do not want Westenhaver Chiropractic to bill my Health Insurance and will chose a different payment option.

Your signature below indicates an understanding of the above document and that you alone are ultimately responsible for all costs for treatment regardless of insurance coverage of attorney agreement.

Date: ______________ Signature of Patient ________________________________

Printed name of Patient ________________________________

CONTRACTUAL GUARANTEE OF PAYMENT FOR HEALTH CARE SERVICES

I hereby authorize and direct you, my attorney, to pay directly to Westenhaver Chiropractic such sums as may be due and owing for health care services for injuries arising from a motor vehicle collision. I hereby authorize my attorney and involved insurance companies to withhold sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor or his office. I hereby further consent to a lien being filed on my case by said doctor or his office against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated.

I agree to never rescind this document and that any attempted recission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney shall honor this Contractual Guarantee of Payment for Health Care Services as inherent in the settlement and enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to said doctor or his office for all health care bills submitted by him for services rendered to me. Further, this agreement is made solely for said doctor's additional protection and in consideration of his forbearance on payment. I understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover damages. Also, I understand that my responsibility to pay Westenhaver Chiropractic's bill is independent and separate from Westenhaver Chiropractic's right to file lien to protect its financial interest under RCW 60.44.

I specifically request my attorney to acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my attórney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payments on a current basis.

Date______________________ Signature of Patient ___________________________

Patient's Driver License Number ___________________________

Patient's Social Security Number ___________________________

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms above, and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor named above.

Date ______________________ Signature of Attorney ___________________________

Please date, sign, and return one original to Westenhaver Chiropractic . Thank You.

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Rivermead Postconcussion Symptoms Questionnaire

After a head injury or accident some people experience problems which can cause worry or nuisance. We would like to know if you now suffer any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident.

For each one please circle the number closest to your answer:

0 = Have not experienced at all
1 = No longer a problem
2 = A mild problem
3 = A moderate problem
4 = A severe problem

Compared with before the accident:

Do you now (i.e., over the last 24 hours) suffer from:

Headaches	0	1	2	3	4
Feelings of dizziness	0	1	2	3	4
Nausea and/or vomiting	0	1	2	3	4
Noise sensitivity, easily upset by loud noise	0	1	2	3	4
Sleep disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being irritable, easily angered	0	1	2	3	4
Feeling depressed or tearful	0	1	2	3	4
Feeling frustrated or impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor concentration	0	1	2	3	4
Taking longer to think	0	1	2	3	4
Blurred vision	0	1	2	3	4
Light sensitivity, easily upset by bright light	0	1	2	3	4
Double vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties?

Please specify and rate as above:

1.________________________________	0	1	2	3	4
2.________________________________	0	1	2	3	4