We are providing this information to assist you in preparing for the possibility of these situations occurring in the course of your motor vehicle accident claim. The first hours and days following a motor vehicle accident can present not only uncomfortable symptoms due to injuries, but also many challenges in dealing with claims adjusters and insurance companies.

Your medical coverage under your insurance policy falls under PIP: Personal Injury Protection. Typically your insurance company will send you an application for benefits, which must be filled out and returned to them before they will process any of your medical bills. If you need help filling this out, let us know. Please be sure to make two copies of that application, one for yourself and one for our office, as the insurance companies seem to lose them quite regularly. We have learned that keeping a journal from the earliest possible time you are able, can be extremely useful. Keeping notes about the details of unfolding events is invaluable if you end up in arbitration or court. Often it is a few years before such a case would finally end up in court, and imagine trying to recall specific symptoms or events 3 years later! It is completely acceptable to take your journal to a witness stand and refer to it to answer questions that you cannot readily recall.

In the first days following a motor vehicle accident, it is very common for claims adjusters to contact you and be advised they will be recording your conversations. It is also useful to realize that while you may have just had a painful, stressful, upsetting accident, the claims adjuster has specifically been trained to minimize the total dollar amount the insurance company will have to pay out on your claim. Their focus is on closing your claim as soon as possible, while you have just entered into a situation you may be totally unfamiliar with, and at a definite disadvantage. The adjuster may ask you questions about your injuries so we would like to point out that it's possible you may not know the extent of your injuries for several weeks. It is **not** in your best interest to discuss your physical condition with adjusters; refer them to your medical providers for information about your condition. Also, please understand that adjusters have no medical training or background required for their position.

If you have previous injuries or treatment for any complaint, it is very important to inform the doctor. The doctor must make specific documentation to differentiate between past problems and current injuries. If for any reason you end up having to go to court, the insurance companies will investigate your past treatment. Another issue is the importance of keeping your doctor appointments. If you miss appointments, or go periods of time without care, the insurance company interprets this as 1) you are fully recovered and need no further care, and 2) if you've gone very long without any care, your symptoms will be considered no longer MVA related. Also, it is our understanding that every auto insurance policy in Oregon has a provision for having seat belts in your vehicle inspected and repaired/ replaced following an accident. Please take advantage of this provision, as even though your seat belts may seem to function correctly, upon another impact in the future, it is possible that may fail to engage properly.

If you are considering obtaining an attorney, please talk to the doctor for guidance. He or she can help you make that decision. It is certainly not our intention to cause added stress by the content of this notice. There are claims that proceed with few problems. We do feel responsible though, to make this information available to those of you who may need it now or in the future. One last note, if you are reading this prior to an MVA, insurance sales people often give you the lowest PIP coverage they have, $10,000. If you are injured in an MVA and need any surgery, i.e. knee surgery, the $10,000 PIP coverage won't cover your medical expenses. For about $5 more per policy period, you can have $50,000 PIP coverage. So, check your policy limits and see what you have on the PIP line.

Accident Information

Tracy & Keim Chiropractic, LLC
1000 River Road
Eugene, OR 97404
Phone(541)689-0935

Date of accident:_____Hour_____AM/PM Location:_____
Have you missed any work? Yes / No If yes, how many days? _____
Type of accident: Work related? _____ Traffic? _____

Work Related Accident:
Employer _____ Type of Business _____
Was any equipment, machinery, and/or object related to accident? _____
Was the accident reported to the supervisor and/or employer? Yes / No
Has a worker's compensation claim been filed? Yes / No
Describe circumstances surrounding the accident:
_____
_____
_____

Traffic Accident:
What kind of vehicle/s were involved? _____
Were you a: Driver _____ Passenger _____ Pedestrian _____
If a passenger, please indicate your location in the car _____
Was your vehicle moving when the accident occurred? Yes / No MPH_____
Did you see the accident coming? Yes / No
At the time of impact, were you looking straight ahead? Yes / No
Did the airbag/s deploy? Yes / No
Did your vehicle hit the other vehicle/s? Yes / No Where? _____
Did other vehicle/s hit your vehicle? Yes / No Where? _____
Were you wearing a seatbelt? Yes / No
Were you treated in the ER? Yes / No Were you transported by ambulance? Yes / No
Did you require post-accident hospitalization? Yes / No
Was the accident reported to the police department? Yes / No
Were traffic citations issued? Yes / No To Whom? _____
Describe circumstances surrounding the accident:
_____
_____
_____

Insurance Companies involved:
My Insurance Company:_____Claim Number:_____

My Insurance Companies Billing Address:_____

Company of person responsible for injuries:_____Claim Number:_____

Attorney's name:_____Telephone_____

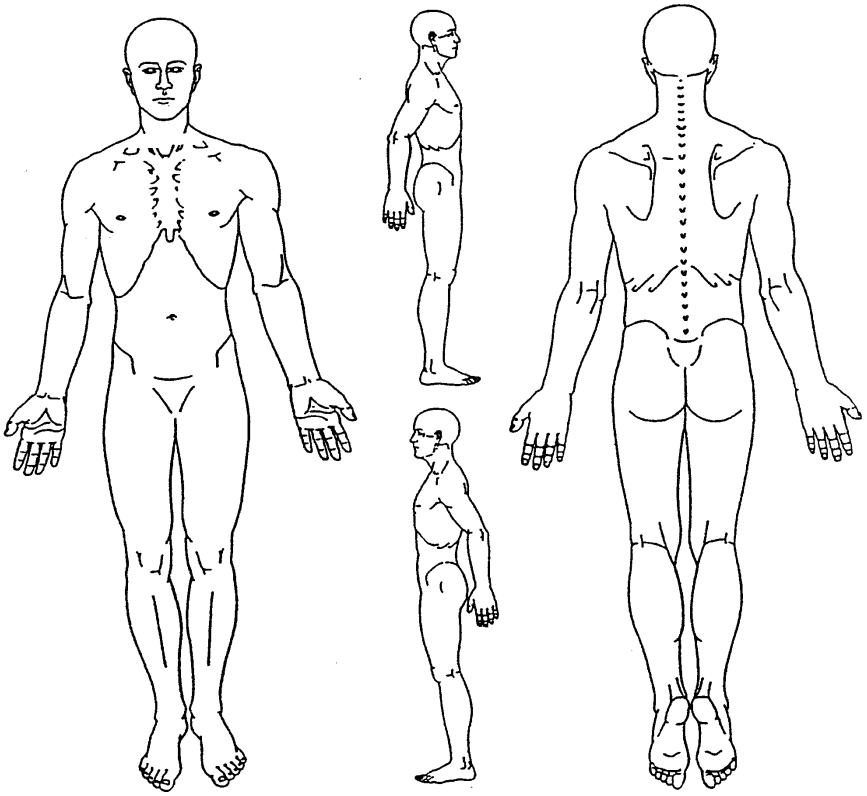
_____
Patient Name **Patient Signature** **Date**

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Type of pain you are currently experiencing…

Place appropriate symbol or letter on the diagram.
Ache= AAAAA
Burning= XXXXX
Cramps= CCCCC
Dull= OOOOO
Numbness= NNNNN
Sharp= SSSSS
Shooting= <<<<<
Stabbing= / / / / /
Throbbing= - - - - -
Tingling= + + + + +
Other Sensation= #####
(Describe it:_____)



Check symptoms you have noticed since the accident:

Headache	Dizziness	Depression	Fatigue
Stomach Upset	Light Bothers Eyes	Buzzing in Ears	Diarrhea
Neck Pain	Head Seems too Heavy	Loss of Memory	Feet Cold
Neck Stiff	Pins and Needles in Arms	Ears Ring	Hands Cold
Fainting	Sleeping Problems	Loss of Balance	Back Pain
Face Flushed	Pins and Needles in Legs	Constipation	Tension
Nervousness	Numbness in Fingers	Loss of Smell	Fever
Irritability	Numbness in Toes	Loss of Taste	Chest Pain
Cold Sweats	Shortness of Breath	_____	_____

Please use the space below to describe your condition further if needed:

_____
_____
_____

Date: _____ Name: _____

Tracy & Keim Chiropractic, LLC, 1000 River Road, Eugene, OR 97404 (541)689-0935

Tracy & Keim Chiropractic, LLC

NECK Pain and Disability Questionnaire

Rate the severity of your pain by circling one number: (No Pain) 0…1…2…3…4…5…6…7…8…9…10 (Excruciating Pain)

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Read through each section and check only ONE line that applies to you. You may find that two of the statements in a section relate to you, but please just check ONE line that best describes your current predicament.

Section 1– Pain Intensity
___ I have no pain at the moment.
___ The pain is very mild at the moment.
___ The pain is moderate at the moment.
___ The pain is fairly severe at the moment.
___ The pain is very severe at the moment.
___ The pain is the worst imaginable at the moment.

Section 2– Personal Care (washing, dressing, etc.)
___ I can look after myself normally without causing extra pain.
___ I can look after myself normally but it causes extra pain.
___ I am slow and careful because it is painful for me to look after myself.
___ I need some help but manage most of my personal care.
___ I need help every day in most aspects of care.
___ I do not get dressed, I wash with difficulty and stay in bed.

Section 3– Lifting
___ I can lift heavy weight without extra pain.
___ I can lift heavy weight but it causes extra pain.
___ I cannot lift heavy weight off the floor, but I can manage if they are conveniently positioned like on a table.
___ I cannot lift heavy weight, but I can manage light to medium weights if they are conveniently positioned.
___ I cannot lift any weight due to neck pain.

Section 4– Reading
___ I can read as much as I want to with no pain in my neck.
___ I can read as much as I want to with slight neck pain.
___ I can read as much as I want to with moderate neck pain.
___ I cannot read as much as I want to due to moderate neck pain.
___ I can hardly read at all because of severe neck pain.

Section 5– Headaches
___ I have no headaches at all.
___ I have slight headaches that occur infrequently.
___ I have moderate headaches that occur infrequently.
___ I have frequent moderate headaches.
___ I have frequent severe headaches.
___ I have severe headaches all the time.

Section 6- Concentration
___ I can concentrate fully when I want to with no difficulty.
___ I can concentrate fully when I want to with slight difficulty.
___ I have a fair degree of difficulty in concentrating when I want to.
___ I have a great deal of difficulty in concentrating when I want to.
___ I cannot concentrate at all.

Section 7- Work
___ I can do as much work as I want to.
___ I can only do my usual work, but no more.
___ I can do most of my usual work, but no more.
___ I cannot do my usual work.
___ I can barely do any work at all.
___ I cannot do any work at all.

Section 8- Driving
___ I can drive my car without any neck pain.
___ I can drive my car as long as I want with slight neck pain.
___ I can drive my car as long as I want with moderate neck pain.
___ I cannot drive my car as long as I want.
___ I can hardly drive at all because of severe neck pain.
___ I cannot drive my car at all.

Section 9- Sleeping
___ I have no trouble sleeping.
___ My sleep is slightly disturbed (less than 1 hour sleepless)
___ My sleep is mildly disturbed (1 hour sleepless)
___ My sleep is moderately disturbed (2 to 3 hours sleepless)
___ My sleep is greatly disturbed (4 to 5 hours sleepless)
___ My sleep is completely disturbed (6 to 7 hours sleepless)

Section 10- Recreation
___ I am able to engage in all my recreation activities with no neck pain.
___ I am able to engage in all my recreation activities with some neck pain.
___ I am able to engage in most, but not all of my usual recreation activities.
___ I am able to engage in a few of my usual recreation activities.
___ I can hardly do any recreation activities.
___ I cannot do any recreation activities due to neck pain.

Patient Name (Print)	Patient Signature	Date

FOR OFFICE USE ONLY:

_____ x 2 =	_____	_____
Total Points	Disability Percentage	Rating Scale

Tracy & Keim Chiropractic, LLC

BACK Pain and Disability Questionnaire

Rate the severity of your pain by circling one number: (No Pain) 0…1…2…3…4…5…6…7…8…9…10 (Excruciating Pain)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Read through each section and check only ONE line that applies to you. You may find that two of the statements in a section relate to you, but please just check ONE line that best describes your current predicament.

Section 1– Pain Intensity
___ the pain comes and goes and is very mild.
___ the pain is mild and does not vary much.
___ the pain comes and goes and is moderate.
___ the pain is moderate and does not vary much.
___ the pain comes and goes and is very severe.
___ the pain is severe and does not vary much.

Section 2– Personal Care
___ I do not have to change my way of washing or dressing In order to avoid pain.
___ I do not normally change my way of washing or dressing Even though it causes some pain.
___ Washing and dressing increase the pain but I manage not to Change my way of doing it.
___ Washing and dressing increases the pain and I find it Necessary to change my way of doing it.
___ Because of the pain I am unable to do some washing and Dressing without help.

Section 3– Lifting
___ I can lift heavy weight without extra pain.
___ I can lift heavy weight but it causes extra pain.
___ I cannot lift heavy weight off the floor, but I can manage if They are conveniently positioned like on a table.
___ I cannot lift heavy weight, but I can manage light to medium Weights if they are conveniently positioned.
___ I cannot lift any weight due to back pain.

Section 4– Sitting
___ I can sit in any chair as long as I like.
___ I can only sit in my favorite chair as long as I like.
___ I cannot sit more than 1 hour because of back pain.
___ I cannot sit more than half hour because of back pain.

Section 5– Standing
___ I can stand as long as I want without pain.
___ I have some pain when standing but it does not increase with Time.
___ I cannot stand longer than 1 hour without increasing pain.
___ I cannot stand longer than ½ hour without increasing pain.
___ I cannot stand longer than 10 mins. Without increasing pain.
___ I avoid standing because it increases pain right away.

Section 6- Sleeping
___ I get no pain in bed.
___ I get pain in bed but it does not prevent me from sleeping.
___ My normal nights sleep is reduced by ¼ due to pain.
___ My normal nights sleep is reduced by ½ due to pain.
___ My normal nights sleep is reduced by ¾ due to pain.
___ Pain prevents me from sleeping at all.

Section 7- Walking
___ I have no pain when walking.
___ I have some pain when walking but it does not increase with distance.
___ I cannot walk more than 1 mile without increasing pain.
___ I cannot walk more than ½ miles without increasing pain.
___ I cannot walk more than ¼ miles without increasing pain.
___ I cannot walk at all without increasing pain.

Section 8- Social Life
___ My social life is normal and gives me no extra pain.
___ My social life is normal but increases the degree of pain.
___ Pain has no significant effect on my social life apart from limiting my more energetic interests (like dancing, etc.).
___ Pain has restricted my social life so I don't go out very often.
___ Pain has restricted my social life to my home.
___ I have hardly any social life because of the pain.

Section 9- Traveling
___ I get no pain while traveling.
___ I get some pain while traveling but none of my usual forms of travel make it any worse.
___ I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
___ I get extra pain while traveling that compels me to seek alternative forms of travel.
___ Pain restricts most forms of traveling.
___ Pain prevents all forms of travel except that done lying down.

Section 10- Changes in the Degree of Pain
___ My pain is rapidly getting better.
___ My pain fluctuates but overall is definitely getting better.
___ My pain seems to be getting better but improvement is slow.
___ My pain is neither getting better or worse.
___ My pain is gradually worsening.
___ My pain is rapidly worsening.

_____	_____	_____
Patient Name (Print)	Patient Signature	Date

FOR OFFICE USE ONLY:

_____ x 2 =	_____	_____
Total Points	Disability Percentage	Rating Scale

Tracy & Keim Chiropractic, LLC
1000 River Road
Eugene, OR 97404

Sharell Tracy, DC
Richard Keim, DC
Megan Wagner, DC

IRREVOCABLE DOCTOR'S LIEN AND ASSIGNMENT OF RIGHT TO RECOVERY

In consideration and exchange for not having to immediately pay a debt owed and in consideration for receiving future care at or by the clinic and doctors on whose letterhead this document is printed (hereinafter "Clinic"), I, the undersigned, hereby assign and convey to the Clinic a legal and equitable interest in any and all causes of action or rights of recovery I may have arising out of that certain accident or injury-producing event which occurred on or about the _____ day of_____,20____, to the full extent of the cost and treatment provided or to be provided me by the Clinic.

I hereby authorize and direct my attorney(s) to hold in trust, and to pay directly to the Clinic such sums as may be due and owing the Clinic for treatment and other professional services rendered me both by reason of this accident and by reason of any other bills that are due the Clinic and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately pay and protect the Clinic. I hereby further give, grant, and convey a lien on my case to the Clinic against any and all proceeds of any and all causes of action, settlements, judgments or verdicts which may be paid to or through my attorney, or myself, as the result of the injuries or conditions for which I have been treated by the Clinic.

I fully understand that I am directly and fully responsible to the Clinic for all bills incurred for services rendered me and that this agreement is made solely for the Clinic's additional protection and in consideration for the Clinic's waiting for payment. I further understand that payment for services rendered by the Clinic is not contingent on any settlement, judgment or verdict by which I may eventually recover. I am personally responsible for my bills, regardless of the outcome of any legal claim or case.

I fully understand that if my attorney(s) does/do not protect the Clinic's interest, the Clinic may require me to make payments on a current basis. In any case, if my balance with the Clinic reaches $1000 and no PIP benefits are available, I understand I may be required to start paying for subsequent services rendered. The Clinic may also bring a cause of action against my attorney(s) for failing to honor this binding and irrevocable agreement between the Clinic and me. I further understand and agree that the Clinic is not responsible for paying any of my attorney's fees and the Clinic does not agree to pay my attorney(s) any attorney fees for honoring this agreement between the Clinic and me.

"I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT, AND I AM VOLUNTARILY SIGNING THIS DOCUMENT. I AM DIRECTING MY ATTORNEY(S) TO PROTECT THE CLINIC'S AND DOCTOR'S INTEREST AT TIME OF SETTLEMENT, AND I AM ASSIGNING AND CONVEYING CERTAIN LEGAL RIGHTS OVER TO THE CLINIC. I ALSO KNOW I MAY NOT REVOKE THIS AGREEMENT AT ANY TIME WITHOUT PRIOR WRITTEN AUTHORIZATION FROM THE CLINIC. I UNDERSTAND THAT, AMONG OTHER THINGS, THIS IS A BINDING AND ENFORCEABLE CONTRACT, ASSIGNMENT, AND LIEN.

_____	_____	_____
Patient Name (Print)	Patient Signature	Date