STARKEY CHIROPRACTIC & WELLNESS

237 LEATHERMAN ROAD WADSWORTH, OH 44281

PHONE (330) 336-2120

Dear Patient,

Please be advised that it is our office policy that when dealing with personal injury cases, we will bill your automobile insurance for medical treatment related to your automobile accident.

Under your personal automobile insurance you have a portion of your policy called the "Med Pay Policy" which covers your medical bills when you are involved in a car accident. Your auto insurance will then subrogate with the auto insurance company of the person who is responsible for the accident for reimbursement. It is your responsibility to contact your auto insurance to let them know you would like to open a claim for medical payment within 24 hours of being treated in my office. They will then give you a claim number for which you will provide my office with for billing purposes.

I have read and understand Dr. Starkey's , Dr. Berardino's and Dr Leonard's policy regarding personal injury claims and I give them full permission to bill my med pay policy under my automobile insurance for services directly related to the automobile accident I was involved in on _____. I further give my insurance company permission to pay Dr. Starkey , Dr. Berardino and Dr. Leonard directly for my medical care.

_____ _____

PRINTED NAME **DATE**

_____

SIGNATURE

_____

WITNESS

STARKEY CHIROPRACTIC & WELLNESS

237 LEATHERMAN ROAD WADSWORTH, OH 44281

PHONE (330) 336-2120

DATE: _____

I do herby authorize Dr. Starkey and Dr. Berardino and Dr Leonard to furnish my attorney and/or insurance company with a full report of their examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved on _____,_____.

I herby authorize and direct my attorney and/or insurance company to pay directly to Dr. Starkey , Dr. Berardino and Dr. Leonard such sums as may be due and owing for medical services rendered me both by reason of this accident and by reason of any other bills that are due this office and to withhold upon receipt of any money on her behalf resulting from the following list:

1. A payment by any insurance company for personal injury protection benefits.
2. Medical payment coverage or under any other parts of my policy or any policy to which I may be entitled; a settlement of any claim.
3. A judgement in my favor or otherwise to adequately protect the office of Dr. Starkey and Dr. Berardino.

I herby further give a lien on my case to Dr. Starkey , Dr. Berardino and Dr. Leonard against any and all proceeds whether by PIP, medical payment or settlement, judgment or verdict which may be paid to you, my attorney, any insurance company, or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to Dr. Starkey , Dr. Berardino and Dr Leonard for all medical bills submitted by them for services rendered to me and that this agreement is made solely for said payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee. A photocopy of this statement shall be as valid as the original.

DATE _____ PATIENT SIGNATURE: _____

WITNESS: _____

THE FOLLOWING INFORMATION IS REQUIRED PRIOR TO YOU RECEIPT OF A NARRATIVE REPORT AND ITEMIZED BILLING.

Motor Vehicle Accident Report Form

Instructions: Please carefully consider and answer each question as completely as possible

Name_____**Today's Date :**_____**Date of Accident:**_____

Insurance Companies Involved

Your Insurance Company _____ Ins. Adjustor Name _____

Other Vehicle Insurance Company _____

Other Vehicle Ins. Adjustor Name _____

Were you the □ Driver □ Passenger □ Pedestrian

Were you struck from □ Behind □ Right Side □ Left Side □ Front □ Auto was parked

Other, explain:_____

Did your car strike the other(s) involved? □ Yes □ No Did the other car strike yours? □ Yes □ No

Were traffic citations issued? □ Yes □ No If "yes", to □ You □ The other driver □ The driver of your car

Did any part of your body strike any part of the car? □ Yes □ No. If "yes", please explain: _____

_____

Did you have a seat belt on? □ Yes □ No Shoulder strap? □ Yes □ No

Does your car have a headrest? □ Yes □ No Height or position? □ Shoulder □ Neck □ Head □ Above

Loss of consciousness? □ Yes □ No If "yes", please explain: _____

_____

Were you stunned? □ Yes □ No How long? _____

Did you feel or hear popping, tearing, or ripping noise in your neck or back? □ Yes □ No

If "yes", please explain: _____

_____

Did you feel any pain? □ Yes □ No Where? _____

How long after the accident? _____

Did you find any bruises? □ Yes □ No Where? _____

List the extent of injuries as you know them: _____

_____

Instructions: Please check symptoms you have experienced since the accident.

- ☐ Headaches
- ☐ Low Back Pain
- ☐ Face Flushed
- ☐ Constipation
- ☐ Skull or Head Pain
- ☐ Low Back Stiffness
- ☐ Loss of Color
- ☐ Excessive Perspiration
- ☐ Neck Pain
- ☐ Hip Pain
- ☐ Dizziness
- ☐ Loss of Perspiration
- ☐ Neck Stiffness
- ☐ Buttock Pain
- ☐ Fainting
- ☐ Loss of Taste
- ☐ Head feels too heavy
- ☐ Leg Pain
- ☐ Sinus Trouble
- ☐ Cold Sweats
- ☐ Shoulder Pain
- ☐ Leg Numbness
- ☐ Loss of Smell
- ☐ Fever
- ☐ Shoulder Stiffness
- ☐ Pins and Needles in Legs
- ☐ Eye Strain
- ☐ Pain in Doing Occupation
- ☐ Arm Pain
- ☐ Numbness in Feet/Toes
- ☐ Difficulty Focusing
- ☐ Swelling. If so, where:

  _____
- ☐ Arm Numbness
- ☐ Cold Feet
- ☐ Pain Behind the Eyes
- ☐ Pins and Needles in Arms
- ☐ Depression
- ☐ Eyes Sensitive to Light
- ☐ Riding in Car
- ☐ Numbness in Hands/Fingers
- ☐ Anxiety
- ☐ Double Vision
- ☐ Bending
- ☐ Cold Hands
- ☐ Tension
- ☐ Buzzing or Ringing in Ears
- ☐ Standing
- ☐ Upper Back Pain
- ☐ Irritability
- ☐ Loss of Balance
- ☐ Sitting
- ☐ Upper Back Stiffness
- ☐ Nervousness
- ☐ Palpitations
- ☐ Walking
- ☐ Mid Back Pain
- ☐ Mental Dullness
- ☐ Shortness of Breath
- ☐ Lifting
- ☐ Mid Back Stiffness
- ☐ Loss of Memory
- ☐ Digestive Problems
- ☐ Twisting and/or Turning
- ☐ Chest Pain
- ☐ Difficulty Sleeping
- ☐ Nausea
- ☐ Rising to Walk
- ☐ Rib Pain
- ☐ Fatigue
- ☐ Vomiting
- ☐ Painful Breathing
- ☐ Tremors
- ☐ Diarrhea

Did you require post accident care or hospitalization? ☐ Yes ☐ No If "yes", where: _____

Were you examined? ☐ Yes ☐ No If "yes", by whom: _____

Were you X-rayed? ☐ Yes ☐ No Was any treatment given? (medication, supports, or recommendations):

_____

What is your occupation? _____

Have you missed work as a result of this accident? ☐ Yes ☐ No If "yes", how many days? _____

Description of Accident

Date of Accident: _____ Time: _____ □ A.M. □ P.M. Weather _____

Road Conditions _____

Streets where accident occurred _____

Your Direction: □ N □ S □ E □ W Other Vehicle Direction: □ N □ S □ E □ W

Your Speed: _____ Other Vehicle Speed: _____

Your Car Type: _____ Other Car Type: _____

Describe the accident in detail: _____

_____

_____

_____

_____

Impact Head Position: □ Up □ Down □ Left □ Right Braking: □ On □ Off

Awareness: □ Very □ Partial □ None

First Aid

Passenger / Passers By / Police / Aid Car / Ambulance / Hospital / Clinic / Home Care

Name:_____ Location:_____ Assistance:_____

Comments: _____

Please report any other important information regarding this accident:

_____

_____

_____

_____

_____

_____

_____

Patient Signature _____ Date _____

Dr. Dianne Elizabeth Starkey, Dr. Patrick Starkey, Dr. Anthony Berardino, Dr. Kellee Leonard

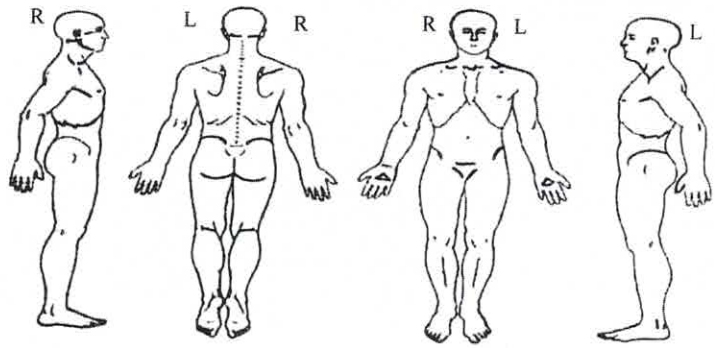
CASE HISTORY

Name: _____ Insurance Change:Yes/No Address change: Yes/No

1. **Describe each Condition / Problem** **Severity** (0=no pain, 10- very severe) **Frequency** Intermittent Occasional Frequently Constant

A)_____	0 1 2 3 4 5 6 7 8 9 10	0 -25%	26-50%	51-75%	76-100%
B)_____	0 1 2 3 4 5 6 7 8 9 10	0 -25%	26-50%	51-75%	76-100%
C)_____	0 1 2 3 4 5 6 7 8 9 10	0 -25%	26-50%	51-75%	76-100%
D)_____	0 1 2 3 4 5 6 7 8 9 10	0 -25%	26-50%	51-75%	76-100%

(Please mark the figures where you experience pain.)➔



2. Symptoms are worse in the (circle what applies)

-morning -Increase during the day
-afternoon -same all day
-night -decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. Symptom (c.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
6. Symptom (d.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
7. Date of Onset: _____/_____ or the time frame of when you last experienced the condition:
   a. __ Acute (within last 3 months) __ Recurrent (multiple episodes <3 months) __ Chronic (continuous > 3 months)
8. How did your symptoms begin? _____
9. Have you experienced these before? When? _____
10. Do your symptoms radiate or cause weakness? _____
11. Any changes to bowel or urinary habits? _____
12. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
13. Circle the activities that make your problems worse:

    Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

14. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____

    If No, what have you tried that has not helped? _____
15. Have you been treated for this before? ___No ___Yes Who/How long ago? _____
16. What treatment did you receive? _____
17. Results of previous treatment? ___Good ___Poor Comments _____
18. Which activities of daily living does this pain interfere with? _____
19. List any other major injuries you have had, other than those mentioned above: _____

_____

20. Have you ever been diagnosed with Covid 19? _____ If yes, when? _____

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____