Patient:_____ File #:_____ Date:_____

Welcome to Insight Chiropractic

Personal Injury New Patient Information

Welcome to Insight Chiropractic!! You have chosen a great office for your chiropractic care!

Please print the New Patient Introduction forms AND the Personal Injury Forms read and answer the forms thoroughly before you come into the office.

New Patient Introduction forms maybe filled out on-line in this PDF format or printed and filled out by hand. Please read and answer the forms thoroughly before you come into the office. The better the history you can provide the better the doctor can understand your condition(s.) If you need, please write on the back of the forms to explain anything further. Please have your paperwork filled out before your first visit, this will ensure more time with the doctor and limit the possibility of returning for another visit because the examination was not completed in the allotted appointment time.

If you have insurance, please bring your insurance card and your photo ID so we can photo copy it and begin your insurance verification process.

Everyone starts as cash patients and then transfers over to other designated patient types (insurance, personal injury, worker's compensation, Medicare) once verification has been determined. Please bring a form of payment for this first visit. If your insurance covers the first visit, then a credit will be placed on your account and future "co-pays/patient portions" will be deducted from the credit balance until the balance is zero.

Please dress in loose fitting sports clothes and expect to be at the office for your first visit at least 1 hour. The doctor will perform a detail history and examination during this time. Based on your history and condition, x-rays or a medical consultation may be necessary before a chiropractic treatment is given. The doctor will alert you when certain circumstances arise and request an x-ray or medical consultation before treating. X-rays or medical consultations help to provide better tools for diagnosis when the need arises.

Your chiropractic treatment is generally provided on your second visit as well as your report of findings; which is a verbal report of the doctor's findings. Additionally, in the next 4 visits after your report of findings you will receive your chiropractic education so you may better understand chiropractic and how various other healthy alternatives help to maintain wellness and long-term prevention care.

Our office consists of various areas of treatment including open adjusting and open exercising areas. Please be aware of your conversations with the doctor, staff and other patients within the office. If needed, private treatment areas are available, please know this option is available up request.

Make sure to bring:

- □ New Patient Introduction Forms
- □ Personal Injury Forms
- □ Liability Insurance Card or Information
- □ Adjustor's Name and Phone #

Please visit the **Contact Us tab** on our website (insightchiropractic.com) for driving directions or to email.

Yours in Health…. Dr. Jennifer L. Forster

Patient:_____ File #:_____ Date:_____

BIKE ACCIDENT FORM

HOW DID YOUR BIKE ACCIDENT HAPPEN?

(Include details such as: Why it happened, how did you respond (i.e., hands reached forward), if your body twisted, if you hit the floor/ground, and what parts of your body that hit)

_____
_____
_____
_____
_____

AT THE TIME OF YOUR ACCIDENT:

Date of injury:_____ Time of injury _____ ☐ AM ☐PM
City where accident occurred: _____
Street (include cross streets): _____
Building/location where accident occurred:_____
The weather condition? _____Was the ground wet or dry? ☐ Wet ☐ Dry

- ☐ Yes ☐ No Did the police come to the accident scene?
- ☐ Yes ☐ No Did the police make a written report?
- ☐ Yes, ☐ No Were you cited by the police? If No, Who was at fault?_____
- ☐ Yes ☐ No Were any photographs taken of the fall area? If yes, who took them?
- ☐ Yes ☐ No Were you injured?
- ☐ Yes ☐ No Were you transported by ambulance to the emergency room?
- ☐ Yes ☐ No Did you seek medical treatment after the fall?
- ☐ Yes ☐ No Have you consulted an attorney?

ACCIDENT DESCRIPTION (Check all that apply to you)

☐ Single-bicycle crash	☐ Hit object	☐ Hit person
☐ Bicycle-to-car/truck crash	☐ Hit or attacked by dog	☐ Other

HELMET USE

- ☐ Yes ☐ No Were you wearing a bicycle helmet?
- ☐ Yes ☐ No Did your helmet break?

AT THE TIME OF IMPACT YOUR BICYCLE WAS:

☐ Slowing down	☐ Gaining speed
☐ Stopped	☐ Moving at steady speed

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:

☐ Slowing down	☐ Gaining Speed
☐ Stopped	☐ Moving at steady speed

Patient:_____ File #:_____ Date:_____

BICYCLE ACCIDENT (Page 2)

DURING AND AFTER THE CRASH, YOUR BICYCLE:

☐	Kept going straight, not hitting anything	☐	Spun around, not hitting anything
☐	Kept going straight, falling down	☐	Spun around, hitting another car
☐	Was hit by a second vehicle	☐	Spun around, hitting object other than car
☐	Flipped end over end	☐	Other

CHECK IF ANY OF THE FOLLOWING PARTS BROKE, BENT, OR WERE DAMAGED ON YOUR BICYCLE

☐ Front wheel	☐ Seat frame	☐ Frame
☐ Rear wheel	☐ Handle bars	☐ Other

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING: Please draw lines and match the left side to the right side.

Head	Front Windshield
Face	Side window
Shoulder	Side door or side of car
Arm/hand	Front grill of vehicle
Front chest wall	Hood of car
Side chest wall	Pavement/Street Surface
Hip/abdomen	Frame of car near windows
Knee	Roof of other vehicle
Leg	Another occupant/animal
Foot	Other

IF SOMETHING HIT YOUR HEAD, DESCRIBE HOW IT HAPPENED

(Include details such as: Why it happened, how did you respond (i.e., hands reached forward), if your body twisted, if you hit the floor/ground, and what parts of your body that hit)

_____
_____
_____
_____
_____

Did you have any bruises or lumps on your head or face? ☐ No ☐ Yes, describe where

_____

Patient:_____ File #:_____ Date:_____

AWARENESS AND BODY POSITION DESCRIPTIONS: *Check all areas that apply to you.*

☐	You were unaware of the impending accident.
☐	You were aware of the impending accident and relaxed before the fall.
☐	You were aware of the impending accident and braced yourself.
☐	Your body, torso, and head were facing straight ahead during your fall.
☐	You had your head and/or torso turned at the time of accident: ☐ Turned to left, ☐ Turned to right Describe how far you were turned/twisted and why you were turned/what were you doing?
☐	
☐	

WHERE ARE YOU HURT?

(Check area(s) where you have had pain or have injury)

	Midback		Shoulder/Arm
	Lowback		Elbow/Forearm
	Gluteus mm		Wrist
	Leg/thigh		Foot/Ankle
	Foot/Ankle		Other:

	Top of your head		Eye area
	Back of your head		Upper jaw area
	Side of your head		Lower jaw area
	Forehead above eyes		Ear region
	Neck region		Other:

HOW SOON DID YOU FIRST NOTICE ANY PAIN/SORENESS AFTER THE ACCIDENT?

☐ Immediately ☐ Few hours later ☐ Same evening ☐ Next morning ☐ 1 day later ☐ Few days later

BRUISING AFTER THE ACCIDNET:

Did your body have any bruising (areas that were visibly black, red, and/or blue) after the accident? ☐ No ☐ Yes
If yes, indicate where bruising was located on your body and what caused the bruising:

_____
_____
_____

IN DETAIL DESCRIBE HOW YOU ARE FEELING NOW? (Include areas of pain, feelings, focus, ability, etc.)

_____
_____
_____

Patient:_____ File #:_____ Date:_____

DISABILITY DATES AND EMERGENCY ROOM

DISABILITY-HAVE YOU BEEN UNABLE TO WORK SINCE YOUR INJURY?

☐ NO, ☐ YES I have lost days (time) off work? If yes, you were off work: ☐ Partially ☐ Completely
Please list all dates off work: From _____ to _____.

If yes, what physical activities (sitting, bending, lifting, walking, etc) have limited your ability to work?
_____
_____

YES	NO	EMERGENCY ROOM
☐	☐	Did you go to the emergency room afterward? If yes, date and time:_____ Name of the emergency room? City:
☐	☐	Did you go to emergency room in an ambulance?
☐	☐	Did you or another person drive you to emergency room? Name of other person:
☐	☐	Were you hospitalized after being seen in the Emergency Room? If yes, how many days:
☐	☐	Did the emergency room doctor take X-Rays? Check what regions x-rays were taken: ☐ Skull/Face x-rays ☐ Rib/Chest x-rays ☐ Neck or Middle back x-rays ☐ Collar bone x-rays ☐ Low back or Hip/Pelvis x-rays ☐ Shoulder, Arm or Hand x-rays ☐ Leg or Foot ☐ Other
☐	☐	Did the hospital or clinic take MRI or CT of your body? If yes, indicate what areas of body: ☐ Skull, ☐ Neck, ☐ Low back or hip/pelvis, ☐ Other
☐	☐	Did you have any broken bones/fractures? If yes, where:
☐	☐	Did you have a splint or cast put on for any sprain or fracture? If yes, type/location:
☐	☐	Did you have any dislocations? If yes, where:
☐	☐	Did you have any cuts or lacerations? If yes, where:
☐	☐	Did you have any skin abrasions? If yes, where:
☐	☐	Did you require any stitching for cuts? If yes, where:
☐	☐	Did you have any visible bruises or lumps? If yes, where:
☐	☐	Did you have any visible bruises along the shoulder or lap portions of your seatbelt?
☐	☐	Did the emergency room doctor give you pain medications?
☐	☐	Did the emergency room doctor give you muscle relaxants?
☐	☐	Did the emergency room doctor give you any other medications/prescriptions?
☐	☐	Were you told you had a herniated or bulging disc in your neck or back? If yes, where:
☐	☐	Were you given a neck collar or back brace to wear?
☐	☐	Did you require any surgery after the accident? If yes, describe type and date:
☐	☐	Were you hospitalized overnight? If yes, indicate dates hospitalized:

Patient:_____ File #:_____ Date:_____

PROVIDERS SEEN SINCE INJURY OR WHEN CONDITION BEGAN

Start with the first doctor that you went to after your injury or your condition began and list all providers (all types of doctors or therapists), up to your last provider seen, and check all that apply for each. Be certain to list these in sequence from first to last.

① Name Emergency Room, hospital/doctor/therapist/center: _____

Adress:_____ Date_____

Indicate what was done:

☐ Exam-consultation	☐ Rehabilitation	☐ Exercises
☐ Exam or consult only (no treatment)	☐ Ultrasound	☐ Acupuncture
☐ X-ray of neck or head	☐ Spinal adjustments	☐ Injection(s)
☐ X-ray of chest/ribs/middle back	☐ Muscle massage/myotherapy	☐ Wrist brace-splint
☐ X-ray of low back/ pelvis/hips	☐ Muscle stimulation	☐ Neck collar (brace)
☐ X-ray of shoulder/arms/legs	☐ Physical therapy	☐ Low back brace
☐ MRI/CT scan	☐ Anti-inflammatory medications	☐ Heat packs
☐ EMG/Nerve conduction study	☐ Pain medications	☐ Ice packs
☐ Other tests	☐ Muscle relaxants	☐ Other: _____

Indicate if treatment with this provider: ☐ Helped, ☐ Did not help, ☐ Made condition worse

② Name hospital/doctor/therapist/center seen: _____

Address:_____ Date _____

Indicate what was done:

☐ Exam-consultation	☐ Rehabilitation	☐ Exercises
☐ Exam or consult only (no treatment)	☐ Ultrasound	☐ Acupuncture
☐ X-ray of neck or head	☐ Spinal adjustments	☐ Injection(s)
☐ X-ray of chest/ribs/middle back	☐ Muscle massage/myotherapy	☐ Wrist brace-splint
☐ X-ray of low back/pelvis/hips	☐ Muscle stimulation	☐ Neck collar (brace)
☐ X-ray of shoulder/arm/leg	☐ Physical therapy	☐ Low back brace
☐ MRI/CT scan	☐ Anti-inflammatory medications	☐ Heat packs
☐ EMG/Nerve conduction study	☐ Pain medications	☐ Ice packs
☐ Other tests: _____	☐ Muscle relaxants	☐ Other: _____

Indicate if treatment with this provider: ☐ Helped, ☐ Did not help, ☐ Made condition worse

③ Name of hospital/doctor/therapist/center: _____

Adress:_____ Date_____

Indicate what was done:

☐ Exam-consultation	☐ Rehabilitation	☐ Exercises
☐ Exam or consult only (no treatment)	☐ Ultrasound	☐ Acupuncture
☐ X-ray of neck or head	☐ Spinal adjustments	☐ Injection(s)
☐ X-ray of chest/ribs/midle back	☐ Muscle massage/myotherapy	☐ Wrist brace-splint
☐ X-ray of low back/pelvis/hips	☐ Muscle stimulation	☐ Neck collar (brace)
☐ X-ray of shoulder/arm/leg	☐ Physical therapy	☐ Low back brace
☐ MRI/CT scan	☐ Anti-inflammatory medications	☐ Heat packs
☐ EMG/Nerve conduction study	☐ Pain medications	☐ Ice packs
☐ Other tests: _____	☐ Muscle relaxants	☐ Other: _____

Indicate if treatment with this provider: ☐ Helped, ☐ Did not help, ☐ Made condition worse

Patient:_____ File #:_____ Date:_____

PATIENT INSTRUCTION AND AUTHORIZATION TO PERSONAL INJURY INSURANCE CARRIER TO MAKE DIRECT PAYMENT TO CHIROPRACTOR

I, hereby authorize and instruct the following insurance carrier_____ to send (mail) all paid monies for diagnostic testing, treatment, and/or medical supplies to the following Doctor/Clinic/Office for all services/supplies billed:

Insight Chiropractic 2435 Forest Ave. Ste. 110 San Jose CA 95128 408-244-0727

SEND AND MAKE ALL PAYMENT CHECKS PAYABLE TO:

Jennifer L. Forster D.C.
2435 Forest Ave. Ste. 110
San Jose, CA 95128
TIN#: 02-0723491
State License #: DC29406

(Doctor, include your name, address, state license number, and tax ID number)

Initial	
	I authorize said Doctor to release any information pertinent to my case to the mentioned insurance carrier.
	A photocopy of this authorization shall be considered as valid as the original.
	I authorize said Doctor to use my name in the "Signature on File" in future billings.
	I authorize direct payment to above Doctor.
	I authorize use of this form on all my insurance submissions (billings).

LIMITED POWER OF ATTORNEY FOR PAYMENT OF CHIROPRACTIC BILLS

I hereby, give limited Power of Attorney, for said Doctor/Clinic, to cash and deposit any sums paid by the above insurance carrier for only the specific injury indicated on this form.

Today's Date: _____

Patient Name (Please Print): _____

Signature of Patient (Policyholder): _____

Signature of Patient/Guardian, if other than Policyholder: _____

Date of Injury: _____

Witness Signature: _____

Patient:_____ File #:_____ Date:_____

Personal Injury Accident Questions:

Date of Injury:
Type of Accident:

Patient's Insurance Information

Name of Insurance Company: _____
Adjustor's Name: _____
Phone #: _____
Claim #: _____
Claim's Address: _____
_____
Claim's Fax#: _____

Med Pay? Y N $_____

Third Party's Insurance Information

Name of Insurance Company: _____
Adjustor's Name: _____
Phone #: _____
Claim #: _____
Claim's Address: _____
_____
Claim Fax#: _____

Accepting Liability? Y N $_____
If Yes and doesn't have Med Pay… place Lien on case and attach a lawyer to case.

Attorney Information

Name of Law Office: _____
Lawyer Name: _____
Phone #: _____
Reference #: _____
Law Office Address: _____
_____

Accepting Case? Y N $_____

Claims Processing Order:

Med Pay
Private Insurance Billing
Lien (if balance accrues)

Patient:_____ File #:_____ Date:_____

Stop

The remainder of the paperwork is for the Doctor to fill out

Please Read

The informative handout at end of this packet for further explanations regarding your accident medical coverage

Patient:_____ File #:_____ Date:_____

Name and address of Chiropractor with whom Patient & Attorney are authorizing lien .
Jennifer L. Forster, D.C.
Insight Chiropractic 2435 Forest Ave. Ste 110 San Jose CA 95128 408-244-0727

LIEN AUTHORIZATION
TO PAY CHIROPRACTIC FEES
-and Constructive Trust for the Chiropractor-

ATTORNEY NAME/ADDRESS:
Date of Injury:

PATIENT NAME/ADDRESS:
Social Security No:

PATIENT AGREEMENT

I hereby authorize the above Chiropractor to furnish you, my attorney, a full report of his/her examination, diagnosis, treatment, and prognosis of my injuries, arising from the accident in which I was involved.

I further authorize and irrevocably direct you, my attorney, **to pay directly to above Chiropractor** such billings and fees as may be due and owing to him/her for these chiropractic services/treatment, X-rays, reports, all deposition time, all arbitration or mediation time, court appearances, transcription time, and costs rendered to me by reason of this accident. You, my attorney, are further irrevocably directed to pay such billings and fees from funds held for me in your client trust account, or to withhold such sums from any settlements, judgments, dispositions, proceeds, payments or verdicts received by you on my behalf as may be necessary to adequately protect above Chiropractor. I hereby further, irrevocably, give a lien on my case to above Chiropractor against any and all proceeds of any settlements, judgments, dispositions, proceeds, payments or verdicts which may be paid to you, my attorney, or myself, as a result of the injuries which necessitated diagnostic testing, examination, and treatment.

I fully realize and understand that I am directly and fully, personally responsible to the above Chiropractor for all chiropractic billing and that ***this obligation is not contingent upon my receiving any settlement for my claim***. With this in mind, I agree to give the above Chiropractor all information concerning any and all insurance policies which may cover my chiropractic treatment and diagnosis. I further agree to notify the said Chiropractor's office and to pay his/her billings at such time as I may personally receive payments made directly to myself from any of the involved insurance carriers.

Should I receive payment for the above Chiropractic fees and have not turned said monies over to the above Chiropractor within thirty (30) days, or should I fail to perform my obligation to pay these fees, then the entire amount of the Chiropractor's billing shall bear interest at the highest rate permitted by law from the date chiropractic services were rendered.

In the event I discharge my present attorney, or change or substitute another attorney, at any time, prior to payment in full for all chiropractic billing and other charges, the new attorney shall honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her. I agree to notify said Chiropractor of any change in attorney status and will provide a signed lien to the Chiropractor within five working days. If my new attorney does not honor this lien for any reason, or if I have no legal representation for any reason, then I will pay all of said Chiropractor bills in full within thirty (30) days.

(Continued on Other Side-Page 2)

Patient:_____ File #:_____ Date:_____

Lien Authorization- (Continued from Side One)
Chiropractor's Name: Jennifer L. Forster, D.C.

PATIENT AGREEMENT CONTINUED (PAGE TWO OF LIEN)

I agree to be responsible for any legal fees, court, or collection agency costs incurred, which may be necessary to enforce this agreement. Those additional expenses for legal or collection agency fees or court costs, will be added on top of the billings and/or fees of said Chiropractor along with the highest interest rate permitted by law, calculated from the date chiropractic services were first rendered. I understand that, in view of the protracted time for cases to be tried, I waive any right to statute of limitations for collections.

I hereby appoint the said Chiropractor at the address on this lien as my Attorney-in-Fact, to act in my name and place, and on my behalf with authority to endorse any checks issued to me in payment for Chiropractic fees. This contract is binding upon me, whether or not signed by my attorney.

A photocopy reproduction of this authorization and signature may be used in place of the original.

PHYSICIAN (CHIROPRACTOR) AGREEMENT

The physician shall provide Attorney, at intervals upon Attorney's request, with complete reports of patient-client's medical condition and care and cost of treatment. The physician agrees to furnish these reports within a reasonable time after each request at a reasonable cost.

ATTORNEY AGREEMENT

The undersigned, being the attorney of record for the above-mentioned patient, does hereby agree to observe all the terms of the above **Chiropractic Lien and agrees to withhold such sums In Trust** from any payments, proceeds, dispositions, settlements, judgments, or verdicts as may be necessary to adequately protect said Chiropractor. This lien is given with the understanding that it applies only to the net proceeds received, after deduction of attorney's fees and costs of suit. Furthermore, this lien is to be treated on a pro rata basis, with all other liens of equal stature. Counsel further agrees to notify said Chiropractor in writing, at such time as this patient's case is surrendered to the patient/client or is transferred to a new attorney. The undersigned also represents and warrants to said Chiropractor that he/she has explained fully to his/her client, all of the legal ramifications of the foregoing chiropractic lien for services rendered including, but not limited to, its irrevocability, its waiver of the defense of the statute of limitations and its provision for direct payments of chiropractic billings. Furthermore, counsel agrees, that after receiving monies, to send payment to said Chiropractor within thirty (30) days or be charged an additional finance charge at the highest interest rate permitted by the law for every month that the suit has been settled and/or chiropractic payments have been received and said Chiropractor remains unpaid. Counsel agrees to pay all legal fees and court costs should this lien necessitate enforcement through the legal process.

EFFECTIVE DATE OF THIS AGREEMENT.

The effective date of this agreement will be the date of its execution by the last of the parties to do so. The foregoing is agreed to by:

Dated:_____ Chiropractor's Signature:_____

Dated:_____ Patient's Signature:_____

Dated:_____ Attorney's Signature:_____

☺ Attorney, please date, sign your name on this agreement, and then promptly return this form to said Chiropractor's office after making a copy for your own records.

Patient:_____ File #:_____ Date:_____

BIKE INJURY REPORT

Patient Name:	Address:	Home Telephone:
Claim No:	Date of Injury:	Date of First Treatment:
Patient Date of Birth:	Name of Employer:	Job Title:
Patient's Description of Slip and Fall:		

Prior Injuries or Illness: List Complicating Factors:	
Prior Treatment for Injury:	☐ No, ☐ Yes If yes, indicate where:
Present Symptoms: (Severity and Frequency)	
Physical Exam Findings:	
Diagnosis:	
Diagnosis:	
X-Ray: (Indicate date/findings)	☐ No X-rays Taken Date Findings ☐ Yes X-rays Taken
Other Testing: (MRI, EMG, CT, etc)	☐ None Name of Test Date Findings ☐ Yes
Types of Treatment Given: (List Modalities, etc)	
Current Treatment Status: (If Discharged give Date)	☐ Discharged From Care Date of Discharge: ☐ Currently Under Care
Response to Therapy:	
Disability Dates:	☐ None, ☐ Yes Indicate Dates:
Prognosis: (If unknown, indicate why)	☐ Good, ☐ Unknown, ☐ Guarded If guarded, Describe:
Permanent Impairment or Disability:	☐ None, ☐ Unknown, ☐ Yes If yes, Describe:
Present Work Restrictions:	☐ None, ☐ Yes If yes, Describe:

Misc Notes:			
Date of Report:	Physician's License Number: DC29406	Physician's Tax ID No: 02-0723491	Physician's phone #: 408-244-0727
Physician's Address(Street, Ste, City, State, Zip): Insight Chiropractic 2435 Forest Ave. Ste. 110 San Jose CA 95128			
Physician's Name: Jennifer L. Forster, D.C.	Signature of Physician:		

Patient:_____ File #:_____ Date:_____

How to Finance Your Treatment After An Accident and Be Compensated for Your Damages

The typical accident victim, fortunately, has not sustained any fractures or the bones. Instead, the injuries suffered are multiple strains and sprains of the ligaments, muscles, and other soft tissues of the spine. These soft tissue injuries are difficult to diagnose and can be quite painful, severe, and long lasting. If not treated early and by the proper methods, they can lead to chronic and disabling complications.

Treatment of Choice

The treatment of choice for soft tissue injuries, the most effective care, is chiropractic. As a patient, you have an absolute right to select the best type of care. The right choice is to seek treatment from a doctor of chiropractic. This is my first and most important recommendation.

Financing Your Treatment

The first question facing you is how to finance your treatment. If you have been injured in an automobile accident, the answer is: through medical payments coverage from an automobile insurance policy. "Med Pay," as this type of coverage is often called, has two main advantages. It pays the medical bills as soon as they are submitted by your doctor, and it pays them without regard to who was responsible for causing the accident.

With Med Pay, you can get the treatment you need and pay your medical bills as you go. You do not have to wait for determination of how the accident happened. An you avoid risk of having to pay bills yourself if the outcome of your personal injury claim should be unfavorable. As long as the treatment is reasonable and necessary, Med Pay will pay your bills, promptly.

Med Pay is extremely important to your recovery. A patient with soft tissue injuries may require diagnostic procedures such as a CAT scan, thermogram, or MRI, or a consultation with a specialist such as a neurologist or orthopedist. These procedures are expensive and usually require immediate payment, Med Pay is often the only way to make sure that you can receive the treatment you need.

My second and equally important recommendation: to pay for your chiropractic and other treatment after an automobile accident- use your Med Pay.

Where do I find Med Pay?

To use Med Pay, you must first find it. Most people do not know whether they have Med Pay coverage. The only sure way to tell is to examine every policy of automobile insurance that may be involved.

Start with your own policy. Review the declarations page, and if there is any questions, call your insurance agent. If your policy does not have Med Pay, do not give up. You may still be covered through someone else's policy.

If you were driving someone else's car, look also at the policy of the registered owner. If you were a passenger, look also as the policy of the driver. You may also be covered by the automobile policy of a relative in whose household you are a permanent resident, even if you physically reside somewhere else. Finally, remember that Med Pay is not limited to injuries sustained in a car. For example, even if you are struck by a car while crossing the street, you are covered.

"But," you may ask, *"isn't it unfair to have my medical bills paid by the insurance of someone who did not cause the accident? Shouldn't the insurance of the person who cause the accident be the one to pay?"* The only correct and fair answer is that both insurance companies should pay.

Your Med Pay insurance should pay because you paid the premiums. The other insurance should pay because, as the injured party, you have the right to bring a lawsuit against the person whose negligence caused the accident. If you are successful, the court will award you a judgment ordering the wrongdoer to pay your damages.

Settlement

When the wrongdoer's insurance company anticipates a judgment against them, they will attempt to negotiate a settlement with you. *Should you settle the case early and then use the proceeds to finance your treatment?* **The answer is absolutely not. You should not look for payment by the wrongdoer's insurance company until your treatment is completed.**

Remember, a settlement is final! When you accept a settlement you must sign a release of all future claims you may have that are related to your accident. If, after a settlement, your injury turns out to be worse than you expected, you cannot reopen your claim. **The time to begin settlement negotiations is only after your treatment is completed.**

"But," you may ask, "If I submit a claim for Med Pay, won't my insurance premiums be raised?" To answer this, it will not help to ask your insurance agent or the claims adjustor. Their responsibility is to sell policies and discourage or otherwise dispose of claims; they have nothing to do with setting or raising rates. This job belongs to the people in your insurance company's underwriting department. These are the ones to ask.

There is one important difference between what you can receive through Med Pay and what you can receive through a settlement from the wrongdoer's insurance company. Med Pay covers your medical bills, and nothing else. A settlement compensates you for all of your damages. In addition to medical bills, it includes loss of earnings, property damage, and the most valuable aspect of a personal injury claim: your pain and suffering.

Please Note: More often than not, when your Med Pay is used for your medical care, your insurance company will requested repayment of your medical claims from the settlement you receive from the wrongdoer's insurance company. When settling your claim, consider this factor and reflect your settlement requests accordingly.

Importance of Medical Records

To be compensated you must prove your damages, and for this, the most effective proof lies in your medical record. It establishes your medical expense, the nature and extent of your injuries, the type and duration of the treatment required, and any disability from work. **Your medical record helps to prove your loss of earnings, and it is the foundation of your claim for pain and suffering.**

This cannot be emphasized enough: *your personal injury claim is only as good as your medical record.*

To build a strong record, it is vital that you cooperate fully with your treating doctor. Follow to the letter the doctors prescribed course of treatment. Avoid delays in seeking care and gaps in the course of treatment; and do not consult with other doctors without a proper referral from your own doctor.

Related Problems as a Result of Your Accident

To support your claim for loss of wages, you should inform your doctor of all your work-related problems so they are properly entered into your medical record. This will enable your doctor to document the duration of your disability and the extent of your restrictions and limitations on work activities, both during and after your recovery.

To enable your doctor to document your pain and suffering, you must also tell your doctor, without reservation, all the problems and difficulties you are experiencing. These may include much more than the pain and discomfort directly caused by your injuries. You also suffer secondary complaints such as dizziness, loss of equilibrium, recurrent headaches, loss of memory, or inability to concentrate.

At home, your usual family routine may be disrupted. Ordinary daily tasks, such as housecleaning, buying groceries, doing the laundry, making repairs, gardening, picking up your children, may become difficult or impossible.

At work, you may find that because of your medical leave or disability restrictions your performance and productivity are lower; raises or promotions have been lost or postponed, or your seniority or job security have been jeopardized.

All of these problems can be alleviated with treatment, and compensated by law. *To resolve your personal injury claim successfully, you must both recover your health and win compensation for your damages. To achieve both of these aims I suggest that you choose chiropractic treatment and use your Med Pay.*

My final recommendation is this: retain an attorney who is experienced in personal injury and who understands and approves of chiropractic.

With your full commitment and cooperation, you and your doctor will be able to speed-up and maximize the recovery of your health. Working together, you will build a strong medical record that contains the full details of all your damages.

Armed with such a record, your doctor will also be able to provide your attorney with a final narrative report that is well supported and convincingly documented. This is essential if your attorney is to win a settlement for you that is both prompt and fair.

Provided as a courtesy by your doctor of chiropractic… Dr. Jennifer L. Forster
Prepared by Silvano Miracchi, Esq. San Jose, CA