Personal Injury Packet

DUPAGE CHIROPRACTIC CENTRE, LTD.

DR. SALLY A. PEPPING
DR. DON MERTES

Dear patient,

Thank you for choosing DuPage Chiropractic Centre to help you with the injuries that you recently sustained. Because situations like this are not only frightening, but can also be confusing, we want you to know that our office specializes in taking care of all aspects of your care. Please do not get overwhelmed with any insurance questions, leave that up to our staff. Your job is simply to follow our doctor's recommended care program so you may regain your health.

Below you will find all the information we will need from your accident. Once we receive all of this information, the case will be handled exclusively by our billing department.

1. Completion of all DuPage Chiropractic paperwork.
2. Copy of your police report if you were given one.
3. If you have not done so already please call your auto insurance and report your accident to them and open up a **med pay claim.**
4. Once you have established a claim under your med pay call our office with your claim number or bring it into your next appointment.

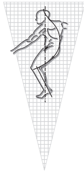
If you have any questions or need help in obtaining this information, please give our office a call Monday, Tuesday, Wednesday, or Friday from 9:30-6:30 and we will be happy to help you. Or you can call Lynn in our billing department directly. She can be reached at 630-858-9780 x3.

We look forward to helping you regain the health that you have recently lost.

Thank you,

Dr. Sally Pepping
Dr. Don Mertes
And Staff

45 S. Park, Suite 155 • Glen Ellyn, IL 60137 • (630) 858-9780 • Fax (630) 858-9793
www.dupagechiropractic.com



DuPage Chiropractic Centre, Ltd

Personal Injury Questionnaire

PERSONAL INFO:

Name: ____________________ Date of Accident: ____________________

INSURANCE INFORMATION:

Carrier's Name:____________________ Phone #: ____________________

Policy #: ____________________ Claim #: ____________________

Adjuster's Name (if have one): ____________________ Adjuster's Phone #: ____________________

Attorney's Name (if have one): ____________________ Attorney's Phone #: ____________________

Other vehicle involved in accident

Carrier's Name: ____________________ Carrier's Phone #:____________________

Driver's Name: ____________________ Policy #: ____________________

NATURE OF ACCIDENT:

Were you: Driver Passenger Front Seat Back Seat

Number of people in your vehicle?____________________ Where you wearing seat belts? ____________________

What direction were you headed? East West South North

Were you stuck from: Front Left Right Behind

Approximate speed of your car? mph____________________ Other car: mph ____________________

Were you knocked unconscious? Yes No If yes, how long?

Were police notified? Yes No

In your own words, describe the accident: ____________________

____

____

____

Did you have any physical complaints before the accident? Yes No

If yes, please describe: ____________________

____

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Where were you taken after the accident? ____________________

Have you been treated by another doctor since the accident? Yes No

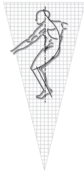
If yes, please list the doctor's name and phone number? ____________________

Circle symptoms you have noticed since accident:

headache	numbness	face flushed	irritability	feet cold
neck pain	shortness of breath	buzzing in ears	chest pain	hands cold
neck stiffness	fatigue	loss of balance	head seems to heavy	stomach upset
sleeping problems	depression	fainting	dizziness	fever
back pain	lights bother eyes	loss of smell	pins & needles in arms	cold sweats
nervousness	loss of memory	loss of taste	pins & needles in legs	constipation
tension	ears ringing	diarrhea	numbness in fingers	

Other pertinent information: ____________________

Patient Signature: ____________________ **Date:** ____________________



DuPage Chiropractic Centre, Ltd

Personal Injury Financial Policy

_______ (Initial) I have been informed and understand that DuPage Chiropractic Centre does NOT accept third party personal injury cases. I understand that I am required to provide either health insurance information or medpay insurance information that will pay for the charges as I receive car. Failure to provide health insurance information and/or medpay information and authorize them to pay for the care will result in myself being billed for all services in full and being required to pay any balance immediately and up front for all care rendered.

_______ (Initial) I understand that any balance remaining after the health insurance or medpay has paid will be sent to third party by DuPage Chiropractic Centre as a courtesy. If settlement of the 3rd party case does not happen within 60 days from the date I am released or cease treatment at DuPage Chiropractic Centre, I agree to make "good faith" payments of no less than $100.00 monthly towards the remaining balance due.

By signing below I am acknowledging that I am aware of the financial policy as it relates to 3rd party personal injury cases and am aware that I need to provide health insurance or medpay information, authorize the medpay or health insurance to pay the claims submitted by DuPage Chiropractic Centre, and am aware that I will be financially liable if I do not abide by this policy. I am also aware that if I do not settle my 3rd part personal injury case within 60 days from the date I cease treatment with DuPage Chiropractic Centre, I will make "good faith" payments of no less than $100 per month until the balance is paid off or settlement occurs.

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Signature of Patient Date

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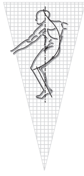
Signature of DuPage Chiropractic Centre Date



DuPage Chiropractic Centre, Ltd

Notice of Physician's Lien

(All patient needs to do is sign and date the bottom)

TO: ________________________
____
____

PLEASE TAKE NOTICE that the undersigned, a duly licensed and practicing chiropractor physician in the State Of Illinois has rendered or will render services by way of treatment to __________of ____________________, ________, IL _____, for injuries sustained on ___/___/______, and for which injuries the following named party or parties is or may be liable to make compensation to said injured person on account of any claims or rights of action which said injured person may have:

NAMES OF PERSONS WHO MAY BE LIABLE AND THEIR ADDRESSES:
____
____
____

YOU ARE HEREBY FURTHER NOTIFIED that the undersigned claims a lien, as provided under the laws of the State of Illinois relating to Physician's Liens, upon all claims and causes of action of said injured person for his reasonable charges for services rendered, up to the date of payment of such damages.

In the event that there is insurance coverage, it is suggested for your protection that this Notice of Physician's Lien be forwarded promptly to the responsible insurance carrier.

Physician's Name & Address:
DuPage Chiropractic Centre
Sally Pepping, D.C.
45 South Park Blvd
Glen Ellyn, Illinois 60137

PROOF OF SERVICE

STATE OF ILLINOIS
COUNTY OF COOK
COUNTY OF DUPAGE

I, ________________________, being of legal age, attest to receiving this lien from DuPage Chiropractic Centre and understand that DuPage Chiropractic Centre will be asserting its lien rights by certified mail to all liable parties or any party listed and that, by signing this lien, I understand that I am liable for all charges as a liable party.

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Patient Signature (as proof of service) Date