Work Injury Questionnaire

Heresco CHIROPRACTIC

Frank Heresco, DC, DABCO
Joseph A. Shepro, DC
Cory A. Imhof, DC
Michael B. McDonald, DC

Name: _____ Date of Birth : _____

1. What was the date of the injury?_____
2. What time did the injury occur?_____
3. What is the name of your employer?_____
4. Please write your employer's address: _____
5. If you have an attorney, what is their name? _____
6. What are the City, State, and Zip of your attorney? _____
7. Please describe your incident in a few sentences: _____

_____

_____

_____

8. Did you report the incident to your supervisor? _____
9. What is your Supervisor's name? _____
10. Did your employer send you to a doctor? If yes, please provide the doctor's name: _____
11. Did you go to a doctor on your own? If yes, please provide the doctor's name: _____
12. Are there any other problems that affect your employment? _____
13. Do you favor any part of your body at work due to this particular injury? _____
14. Before the injury, were you capable of performing equal work with others your age? Yes No
15. Have you injured this area before? Yes No

_____ _____

Signature Date

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massage • strength rehab

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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 Heresco Chiropractic and the doctors whose letterhead this document is printed Heresco Chiropractic 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 to 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 if my attorney(s) does/do not protect the Clinic's interest, the Clinic may require me to make payments on a current basis. The Clinic may also bring a cause of action against my attorney(s) for failing to honor this binding and irrevocable agreement between me and the clinic.

I further understand and agree that the Clinic is not responsible for paying any of my attorneys fees and the Clinic does not agree to pay my attorney(s) and attorney fees for honoring this agreement between me and the clinic.

" 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 AND DOCTOR'S INTEREST AT TIME OF SETTLEMENT, AND I AM ASSIGNING AND CONVEYING CERTAIN LEGAL RIGHT OVER TO THE CLINIC. I ALSO KNOW I MAY NOT REVOKE THIS AGREEMENT AT ANY TIME WITHOUT PRIOR WRITTEN AUTHRIZATION FROM THE CLINIC. I UNDERSTAND THAT, AMONG OTHER THINGS, THIS IS A BINDING AND ENFORCEABLE CONTRACT, ASSIGNMENT, AND LIEN."

_____ _____
Patient Name (Printed) Date of Birth

_____ _____
Patient Name (Signature) Date

_____
Insurance Dept. Witness Signature