



**MEDICAL INTAKE FORM**

Date: \_\_\_\_\_ Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Please Circle: Male or Female

Marital Status (please circle): S M D W Social Security Number: \_\_\_\_\_ E-Mail \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Please list condition(s) in order of concern:**

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

Is this condition(s) related to an auto accident or work injury? YES \_\_\_\_\_ NO \_\_\_\_\_

Describe: \_\_\_\_\_

When did this condition begin/when did you first notice it: \_\_\_\_\_

Describe: \_\_\_\_\_

What activities aggravate your symptoms? \_\_\_\_\_

Is there anything that has relieved your symptoms? YES \_\_\_\_\_ NO \_\_\_\_\_

Describe: \_\_\_\_\_

Have you experienced this condition before? YES \_\_\_\_\_ NO \_\_\_\_\_ Who have you seen for this? \_\_\_\_\_

What did they do? \_\_\_\_\_ How did you respond? \_\_\_\_\_

How committed are you to getting rid of your problem? Very Committed \_\_\_\_\_ Not very Committed \_\_\_\_\_

**Medical History: Please check all that apply**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Migraine Headaches           |
| <input type="checkbox"/> Allergies (Hay fever)    | <input type="checkbox"/> Diverticular Disease         | <input type="checkbox"/> Neurological Problems        |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Emphysema                    | <input type="checkbox"/> Sinus Problems               |
| <input type="checkbox"/> Alcoholism               | <input type="checkbox"/> Eyes, Ears, Nose Throat      | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Blood Pressure           | <input type="checkbox"/> Environmental Sensitivities  | <input type="checkbox"/> Obesity                      |
| <input type="checkbox"/> Bronchitis               | <input type="checkbox"/> Fibromyalgia                 | <input type="checkbox"/> Osteoporosis                 |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Gastroesophageal Reflux      | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Glaucoma                     | <input type="checkbox"/> Seasonal Affective Disorder  |
| <input type="checkbox"/> Carpal Tunnel Syndrome   | <input type="checkbox"/> Gout Heart Disease           | <input type="checkbox"/> Skin Problems                |
| <input type="checkbox"/> Cholesterol-Elevated     | <input type="checkbox"/> Infection, Chronic           | <input type="checkbox"/> Ulcer                        |
| <input type="checkbox"/> Circulatory Problems     | <input type="checkbox"/> Inflammatory Bowel Disease   | <input type="checkbox"/> Urinary Tract Infections     |
| <input type="checkbox"/> Colitis                  | <input type="checkbox"/> Irritable Bowel Syndrome     | <input type="checkbox"/> Varicose Veins               |
| <input type="checkbox"/> Dental Problems          | <input type="checkbox"/> Kidney or Bladder Disease    | <input type="checkbox"/> Thyroid                      |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Liver or Gallbladder Disease | Other _____   |



**Operations:**

- |                                       |  |                                       |
|---------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Prostate     | <input type="checkbox"/> Tonsillectomy   | <input type="checkbox"/> _____        |

**Allergies (please list):**

- |                                |                                |                                |
|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
|--------------------------------|--------------------------------|--------------------------------|

**Please list any prescription medications, OTCs (over the counter medications), vitamins, minerals, supplements you are taking. Please list the amounts (i.e. 500 mg tablet 2x/day), when you take them (schedule) and why you are taking them. If you need more room, use bottom and/or back of page.**

**Prescription Medications**

---

---

---

---

---

---

---

---

---

---

**Over-The-Counter Medications**

---

---

---

---

---

---

---

---

---

---

**Vitamins/Minerals**

---

---

---

---

---

---

---

---

---

---

**Other Supplements**

---

---

---

---

---

---

---

---

---

---





MVA

## INFORMATION FOR MVA BILLING

**\*\*All information must be present\*\***

**Patient Name:** \_\_\_\_\_

**Patient DOB:** \_\_\_\_\_

**Specific DATE OF INJURY:** \_\_\_\_\_

**Patient's Auto Insurance Carrier Name:** \_\_\_\_\_

**Insurance Address:** \_\_\_\_\_

\_\_\_\_\_

**Patient' Auto Insurance Phone Number:** \_\_\_\_\_

**Auto Insurance Claims Adjuster Name:** \_\_\_\_\_

**Auto Insurance Claims Adjuster Phone Number:** \_\_\_\_\_

**Accident CLAIM NUMBER:** \_\_\_\_\_

**\*If accident occurred in Indiana, we will need the other driver's insurance information also.**

**Insurance Information Verified By:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**NOTES: (FOR OFFICE USE ONLY)**



## PLEASE ANSWER THE FOLLING QUESTIONS

1. Were you the  driver  the passenger  a pedestrian  on a bicycle  on a motorcycle
2. Were you  hit (by another vehicle) or  at fault (you caused the accident)?
3. From which side were you struck?  
 behind  the front  the right side  the left side  the right front  the left front  the right back  the left back.
4. At the time of impacted were you:  
 stopped  moving  walking  standing still  running  bicycling  riding a motorcycle  crossing the street.
5. Was your vehicle moving at the time of the accident?  yes or  no If yes, what was your speed \_\_\_\_\_?
6. Was the involved party's vehicle moving when the accident occurred?  yes  no, If yes what was there speed \_\_\_\_\_?
7. Did you have your seatbelt on at the time of the accident?  yes  no
8. Was your head turned at the time of the accident?  yes  no, If yes, were you looking  forward  looking to the right  looking to left  
 looking behind you  looking up  looking down.
9. Were you alone at the time of the accident  yes or  no?
10. What parts of your body hit other structures at the time of impact  head  face  forehead  back of head  
 right shoulder  left shoulder  right arm  left arm  right elbow  
 left elbow  right wrist  left wrist  right hand  left hand  
 right leg  left leg  right knee  left knee  right ankle  left ankle  
 right foot  left foot
11. What structures did you hit?  steering wheel  windshield  side window  door  roof  dashboard  headrest  seat  floor  side of car  hood of car  bumper  trunk  
 the pavement  a tree  another car  another person  another object  a wall
12. How did you feel after the collision?  stunned  disoriented  lost consciousness  tightness  felt mild discomfort  felt moderate discomfort  felt severe discomfort  felt intense pain  frightened  felt a popping and ripping sensation  went to hospital
13. Who was cited for the accident  me  other driver



**Physical History: Please check all that apply.**

- Head:**
- Headaches-one sided
  - Confusion, Brain Fog
  - Blurred Vision
  - Other \_\_\_\_\_
  - Headaches-involves back of neck
  - Dizziness, Unsteadiness
  - Headaches-associated with light sensitivity
  - Headaches-interfere with work
  - Change in memory
- Eyes**
- Itching
  - Glaucoma
  - Sensitive to light
  - Dryness
  - Cataracts
  - Corrective Lenses
  - Puffy under eyes
  - Dark circles
  - Other \_\_\_\_\_
- Ears:**
- Hearing Loss
  - Drainage
  - Ringing/Roaring
  - Other \_\_\_\_\_
  - Pain
- Nose:**
- Itches
  - Runs
  - Blood streaked mucous
  - Sneeze
  - Requires nose drops/spray
  - Other \_\_\_\_\_
  - No sense of smell
  - Sinus infection
- Mouth and Throat**
- Snore
  - Wears dentures
  - Neck glands swell
  - Bad breath
  - Hoarseness
  - Difficulty swallowing
  - Sore throats
  - Grind teeth in sleep
  - Other \_\_\_\_\_
- Cardiac and Respiratory**
- Wheeze
  - Rapid heart beats
  - Non-productive cough
  - Ankle swelling
  - Bronchitis
  - Chest pains
  - Skipped beats
  - Short of breath
  - Murmur
  - Productive cough
  - Cough up blood
  - Night sweat
- Gastrointestinal/Digestion**
- Heartburn
  - Cramping
  - Stomach aches
  - Rectal bleeding
  - Belching frequently
  - Indigestion
  - Mucous in stool
  - Anal pain
  - Diarrhea
  - Blood in stool
  - Nausea/Vomiting
  - Bloating
  - Excess gas
  - Constipated
  - Other \_\_\_\_\_
- Urinary and Genitalia:**
- Frequent urination
  - Kidney stones
  - Yeast infection
  - Unsatisfactory sexual relations
  - Present or previous cancer of the kidneys or urinary tract
  - Painful urination
  - Weak stream
  - Difficulty starting urination
  - Burning
  - Pass blood
  - Genital herpes
  - Lumps, pain swelling testicles
- Endocrine**
- Fatigue
  - Heat intolerance
  - Crave sugar
  - Reaction time slowed down
  - Feel puffy or swollen all over your body
  - Feel cold, chilled-hands, feet all over for no apparent reason
  - Sleepiness in the afternoon
  - Light headed upon standing
  - Difficult getting out of bed
  - Deepening of voice
  - Cold intolerance
  - Crave salt
  - Catch colds or infections easily
  - Loss of libido
  - Weight gain for no apparent reason
- Musculoskeletal**
- Muscle weakness
  - Morning stiffness
  - Back pain
  - Numbness/tingling of hands and feet
  - Parts of the body feel tender, sore, sensitive to touch
  - Other \_\_\_\_\_
  - Muscle cramps
  - Joint swelling, pain or stiffness
  - Increased redness, warmth of joint
  - Decreased strength
  - Muscle twitching



**Skin:**

- |  |                                      |                               |
|--|--------------------------------------|-------------------------------|
| <input type="checkbox"/> Eczema        | <input type="checkbox"/> Hives       | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Dry skin    | <input type="checkbox"/> Oily |
| <input type="checkbox"/> Brittle nails | <input type="checkbox"/> Other _____ |                               |

**Psychological:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Often unhappy             | <input type="checkbox"/> Use tranquilizers               | <input type="checkbox"/> Am a workaholic            |
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Considered a nervous person     | <input type="checkbox"/> Extremely shy or sensitive |
| <input type="checkbox"/> Misunderstood by others   | <input type="checkbox"/> Easily flare in anger           | <input type="checkbox"/> Difficulty staying awake   |
| <input type="checkbox"/> Unable to concentrate     | <input type="checkbox"/> Frequently keyed up and jittery | <input type="checkbox"/> Other _____                |

**Social History: Please circle all that apply.**

Married: Yes No If yes, how long \_\_\_\_\_

Children: Yes No If yes, how many \_\_\_\_\_

Occupation \_\_\_\_\_

Cigarettes: Yes No If yes, how much/day \_\_\_\_\_ How many years \_\_\_\_\_

Cigars: Yes No If yes, how many/day \_\_\_\_\_ or week \_\_\_\_\_

Chewing Tobacco: Yes No

Alcohol: Yes No If yes, drinks/day or week \_\_\_\_\_

Coffee: Yes No If yes, cups/day \_\_\_\_\_

**PMI/FH:**

Have you or any of your family members had any of the problems listed in this chart? Please indicate by checking the appropriate box.

	Father	Mother	Grandparents	Siblings	Children
Alcoholism					
Anemia					
Arthritis					
Asthma					
Cancer					
Diabetes					
Emphysema					
Heart Disease					
High Blood Pressure					
Osteoporosis					
Mental Illness					
Thyroid Disorders					
Others-List					

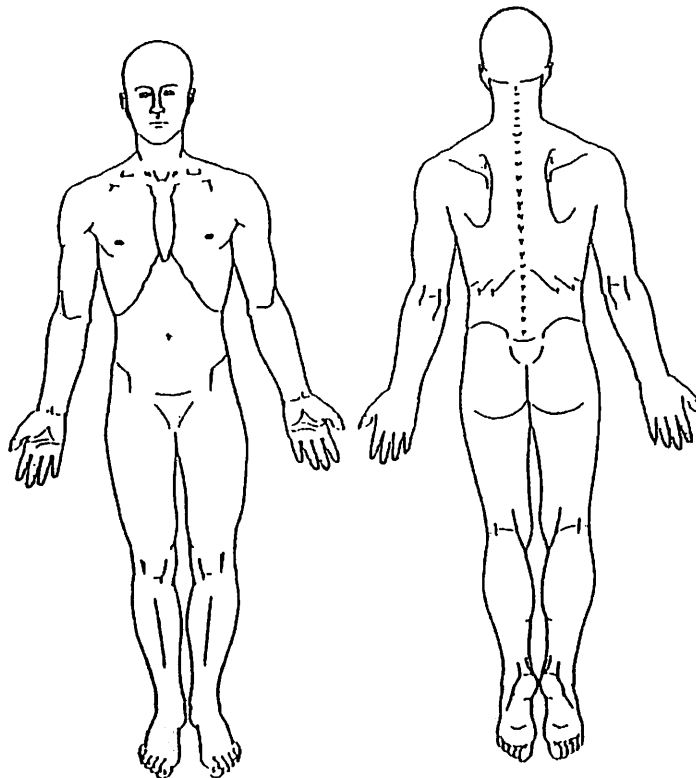


MVA

Please check the boxes below that reflect any symptoms that you may be experiencing or experienced in the past 6 months:

	Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling
Head							
Neck							
Upper Back							
Mid Back							
Lower Back							
Shoulder							
Arm							
Forearm							
Wrist							
Hand							
Ribs							
Buttock							
Hip Thigh							
Leg							
Knee							
Ankle							
Foot							

Please circle/mark your area(s) of the signs and symptoms listed above.





MVA

## INSURANCE COMPLIANCE INFORMATION

We would like to take a moment to welcome you to our office and assure you that your treatment is our top priority. We find that many patients are very confused when using their insurance and are concerned about their financial obligations. This form is utilized to explain your responsibilities when our office files your insurance.

At Dynamic our staff provides you with all insurance filing at the time of service. We will verify all insurance benefits to assure your chiropractic/medical coverage's in full. However, we need to make you aware that these benefits are not a guarantee of payment and you will ultimately be responsible for all services that are not paid by your insurance company. It is very important that you understand that our office, as a service to our patients, will submit and make all attempts to collect all outstanding payments. We will not enter into any disputes with your insurance company. If your account remains in an outstanding status, our staff may request your help in expediting payment from your insurance company.

Each patient is required to meet their deductible in full before their insurance company will pay their portion. At this time, our staff will notify you of your out of pocket expense at your time of service. Most insurance company policies require a payment of 30%-50% of the patients visit. Our staff is required to collect this amount at the time of service. If your insurance policy requires a co-pay, this amount will be requested at the time of service. It has become a standard that doctors' request all payment in full at the time of service. Our office continues to service our patients the old fashion way and will do the work for you. This allows you to focus on your health.

### Personal Injury Patient With Health Insurance:

If you were involved in an automobile accident and have a health care policy, our office will submit all charges at the time of service. You will not be responsible to pay for any deductible or co-pay at the time of service. Any outstanding balance will be reimbursed by your attorney when your case is settled.

### What To Do When My Insurance Company Sends Me A Check:

Many insurance companies will send the member (patient) a check to your home instead of our office by accident. If this situation occurs, please be advised that you are to bring the check and accompanying explanation of benefits to the office so that it can be posted to your account.

### What Do I Do If My Insurance Company Sends Me Forms That I Do Not Know How To Answer?

Many times an insurance company will send a patient a questionnaire for them to fill out. These forms purposely are used as stall tactics and are quite confusing for you to understand. When you receive these letters, please either call our office or bring them to our office manager for proper clarification.

### Financial Consent/Patient Agreement:

I understand and agree to the services that my doctor has offered to me. I agree to be fully responsible for any services that are not paid by my insurance company and understand that my doctor will send all outstanding accounts to a collection agency after 60 days if not reconciled by the responsible party.

I am not an agent or representative of any insurance company or any other business trying to collect information. All injuries/problems mentioned are true and I am here solely for the treatment of the said problems.

Patient Initials: \_\_\_\_\_ Date: \_\_\_\_\_



MVA

**IRREVOCABLE ASSIGNMENT, LIEN AND AUTHORIZATION**  
**INSURANCE BENEFITS**

TO WHOM IT MAY CONCERN:

I hereby authorize and direct you, my insurance carrier to pay directly to Dynamic such sums as may be due and owing this office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident, Workers' Compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect Dynamic I hereby further give lien to said office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated for by Dynamic. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due the office for services rendered. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the office to await payments, and they may demand payments from me immediately upon rendering services at their option.

I authorize the office to release any information pertinent to my case to any insurance carrier or adjuster to facilitate collection under this Assignment, Lien and Authorization.

I further understand and agree that if Dynamic must take any action to collect an outstanding balance on this account, I will be responsible for payment of and will reimburse this office for all costs of such collection efforts, including but not limited to all court costs and all attorney fees.

\_\_\_\_\_(SEAL) \_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Insurance Company Name and Address

**PATIENT ACKNOWLEDGEMENT OF**  
**RECEIPT OF NOTICE**

I hereby acknowledge receipt of the Notice of Privacy Practices for Dynamic regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized and disclosed by Clinic and my respective rights contained there in. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting Dynamic 3707 Chamberlain Ln Louisville, KY 40241 (502) 426-9200

My signature herein below constitutes full acknowledgement that I have furnished a copy of the Notice of Privacy Practices for Dynamic

PRINT Patient's Name: \_\_\_\_\_

SIGNATURE of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

SIGNATURE of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



MVA

**CONSENT TO TREAT**

I hereby authorize the Doctor's to treat my case as they deem appropriate through the use of physical therapy, rehabilitation, manual therapy, chiropractic manipulation of the spine, nutritional support, trigger point injection and diagnostic testing. I realize the goal of holistic healthcare is to strengthen the patient's body in order to heal themselves.

It is understood and agreed the amount paid the clinic for x-rays is for interpretation and only the x-ray negatives will remain the property of this office, being on file. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Initials \_\_\_\_\_

Date: \_\_\_\_\_

**X-RAY QUESTIONNAIRE: FOR WOMEN ONLY**

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: \_\_\_\_\_

- There is a possibility that I may be pregnant at this time.
- Yes. I am definitely pregnant
- No. I am definitely not pregnant at this time
- I request that x-ray films not be taken because \_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_

\_\_\_\_\_  
Patient Initials

\_\_\_\_\_  
Date

**NOTE: Your health information will be kept strictly confidential.** Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.



MVA

## HIPPA / HEALTH CARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES **DYNAMIC** TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Dynamic to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

I give permission to Dynamic to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a Doctor in private, the Doctor will provide a private room for these conversations. By signing the following you are giving Dynamic Chiropractic and Rehab permission to use and disclose your protected health information in accordance with the directives listed above

### ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I \_\_\_\_\_ on this date \_\_\_\_\_ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges:

- \* The right to review the notice prior to signing this consent
- \* The right to object to the use of my health care information for directory purpose
- \* The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations

### PLEASE READ THE FOLLOWING

At this time, we ask that you hand your applicati on to the front desk. They will now assist you on how you will describe your **complaints and/or symptoms** on the Kiosks in the lobby. Please be sure to mark all areas of discomfort, one area at a time. Thank you.

# APPLICATION FOR BENEFITS - PERSONAL INJURY PROTECTION KENTUCKY NO-FAULT

- IMPORTANT:**
1. To enable us to determine if you are entitled to benefits under the policyholder's contract, you must complete and sign this form.
  2. You must also sign the attached authorization(s).
  3. Return promptly with any medical bills you have received to date. However, you should not wait for your medical bills to arrive before sending this application to us. Please send this application back immediately.

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NO.
------	------------------	------------------	----------

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

\_\_\_\_\_

Claim Dept.

YOUR NAME	HOME PHONE NUMBER	WORK PHONE NUMBER
-----------	-------------------	-------------------

YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)

DATE OF BIRTH	SOCIAL SECURITY NUMBER
---------------	------------------------

DATE AND TIME OF ACCIDENT:

BRIEF DESCRIPTION OF ACCIDENT:

DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN A MOTOR VEHICLE?	YES	NO
---	-----	----

PLEASE LIST ALL AUTO INSURANCE CARRIERS CURRENTLY COVERING ANY OR ALL OF THE VEHICLES YOU OWN NAME OF INSURANCE COMPANY AND POLICY # :

WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	YES	NO
---	-----	----

WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	YES	NO
--	-----	----

WERE YOU A PEDESTRIAN ?	YES	NO
-------------------------	-----	----

WERE YOU A MEMBER OF THE MOTOR VEHICLE OWNER'S HOUSEHOLD?	YES	NO
---	-----	----

HAVE YOU REJECTED NO-FAULT COVERAGE (I.E. PERSONAL INJURY PROTECTION COVERAGE) AS PROVIDED BY THE KENTUCKY NO-FAULT ACT (KAS304.39) BY SIGNING A REJECTION FOR THIS COVERAGE?	YES	NO
---	-----	----

WERE YOU INJURED AS A RESULT OF THIS ACCIDENT	YES	NO
---	-----	----

IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM.  
IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

DESCRIBE YOUR INJURY:

WERE YOU TREATED BY A DOCTOR: YES NO

DOCTOR'S NAME AND ADDRESS:

IF YOU WERE TREATED IN A HOSPITAL WERE YOU AN IN-PATIENT OUT-PATIENT

HOSPITAL'S NAME AND ADDRESS:

AMOUNT OF MEDICAL BILLS TO DATE: \$

WILL YOU HAVE MORE MEDICAL EXPENSES? YES NO

AT TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES NO

DID YOU LOSE WAGES OR SALARY AS RESULT OF YOUR INJURY? YES NO

IF YES, AMOUNT TO DATE:

WHAT IS YOUR AVERAGE WEEKLY WAGE/SALARY?

IF YOU LOST WAGES, DATE DISABILITY FROM WORK BEGAN:

DATE YOU RETURNED TO WORK:

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER:

WORKMEN'S COMPENSATION LAWS?	YES	NO
SOCIAL SECURITY BENEFITS?	YES	NO

IF YOU ARE CLAIMING LOST WAGES, COMPLETE THIS SECTION, DOING SO WILL HELP US PROMPTLY VERIFY YOUR SALARY RATE WITH YOUR EMPLOYER.

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
----------------------	------------	------	----

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
----------------------	------------	------	----

HAVE YOU HAD ANY OTHER EXPENSES AS A RESULT OF YOUR INJURY? YES NO

IF YES, EXPLAIN:

I hereby authorize release of medical information, including but not limited to medical bills and reports, to such persons as the company may deem necessary.

Signature \_\_\_\_\_ Date \_\_\_\_\_

IMPORTANT: CHOOSE ONE OF THE REIMBURSEMENT METHODS LISTED BELOW.

PLEASE PAY ME DIRECTLY       PLEASE PAY MY MEDICAL PROVIDER DIRECTLY  
IF WE PAY YOU DIRECTLY, YOU WILL BE RESPONSIBLE FOR PAYING YOUR MEDICAL PROVIDERS PROMPTLY, IF YOU FAIL TO PAY YOUR MEDICAL PROVIDERS PROMPTLY, COLLECTION PROCEEDINGS AND INTEREST CHARGES MAY BE BROUGHT AGAINST YOU.

---

YOU MAY DIRECT THE PAYMENT OF PERSONAL INJURY PROTECTION COVERAGE TO THE DIFFERENT COVERED EXPENSES (WAGE LOSS, REPLACEMENT SERVICES, AND/OR MEDICAL EXPENSES) UNDER PIP ON A PROSPECTIVE BASIS. PLEASE DESCRIBE, IN WRITING, HOW YOU WOULD LIKE YOUR PERSONAL INJURY PROTECTION BENEFITS TO BE DISTRIBUTED AMONG THE DIFFERENT COVERED EXPENSES UNDER PIP.

---

IF YOU DO NOT DESCRIBE, IN WRITING, HOW YOU WOULD LIKE YOUR PERSONAL INJURY PROTECTION BENEFITS TO BE DISTRIBUTED, THEN BENEFITS WILL BE PAID ON A MONTHLY BASIS AS YOU INCUR MEDICAL EXPENSES, WAGE LOSS, AND/OR REPLACEMENT SERVICES LOSS.

NOTE THAT THE MAXIMUM AMOUNT WE WILL PAY FOR WAGE LOSS OR REPLACEMENT SERVICES IN ANY ONE WEEK IS \$200.

---

-DO NOT DETACH-

IF YOU ARE CLAIMING MEDICAL EXPENSES, PLEASE SIGN THE FOLLOWING:  
AUTHORIZATION FOR MEDICAL INFORMATION

This authorization or photocopy hereof will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-ray and physical findings, diagnosis and prognosis. You are authorized to provide this information in accordance with the Personal Injury Protection Benefits (Kentucky No-Fault) Law.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

IF YOU ARE CLAIMING LOST WAGES, PLEASE SIGN THE FOLLOWING:  
AUTHORIZATION FOR WAGE AND SALARY INFORMATION

This authorization or photocopy hereof will authorize you to furnish all information you may have regarding my wages or salary while employed by you. You are authorized to provide this information in accordance with Personal Injury Protection Benefits (Kentucky No-Fault) Law.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Social Security No. \_\_\_\_\_