



Auto Accident Information Sheet

Patient: _____ Date of Accident: _____

Insurance Company: _____

Address: _____

Phone #: _____ Adjuster: _____

Policy Holder's Name: _____

Policy #: _____ Claim Number: _____

When we do not receive payment directly from your insurance company:

Occasionally we encounter an insurance company which will mail payment for our services to the patient who received care, rather than directly to us. It is our expectation that if you receive payment for our services from your insurance company, you will contact us immediately. We expect you to turn over those insurance checks to us directly within one week of the date you receive them. If we determine that you have received payment on our behalf and failed to contact us, you will be provided with written notice that we expect immediate payment of the full amount that you have received. You will then be given 15 days notice prior to the account being turned over to our collection agency.

Please sign below that you understand the above policies and agree to the terms above

Signature

Print Name

Date

Notice: If you have an attorney involved in your case, we need to know immediately to get the appropriate paperwork signed. Please request the Attorney Information Form.

We put healing in motion.