Name:_____
DOB:_____

If this is a Worker's Compensation/Auto/Personal Liability Injury, please provide the information below.

Name of Worker's Compensation/Auto/Personal Liability Injury Insurance:_____

Address of Worker's Compensation/Auto/Personal Liability Injury Insurance:
_____

_____

Telephone Number of Insurer: _____

Adjuster Name: _____

Adjuster Phone: (_____)_____

Adjuster Fax: (_____)_____

Date of Injury: _____

Claim Number: _____

Your Social Security #: _____

Your employer name and address at time of injury: _____

_____

Name of Health Insurance: _____
(Please bring card so we can copy)

Please initial in the space provided to acknowledge that you have read the information below.

_____ Please note once a denial from work comp or auto is received, we will file to your health insurance. If there is a legal case pending, the account balance is the patient's responsibility and payments are still due. If your workers' compensation/auto insurance in the future decides to accept responsibility for the medical expenses, our office will promptly return your payments.

_____ If this is a No-fault Claim/Liability Claim, the full amount of account balance is due. There will be no negotiation.