MOTOR VEHICLE ACCIDENT INTAKE FORM

☐ Motor Vehicle Accident - In which state: _____ ☐ Job-related Auto Collision - Employer: _____

☐ At fault ☐ Not at fault

Patient Information:

DOB: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ Date of accident: _____

Referring Provider: _____ Phone: _____

Insurance Information:

Insurance Co. (Yours or of the car you were in): _____

Insured's Name (if it is other than yours): _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Claim Number: _____ Claims Adjuster's Name: _____ Phone: _____

At-fault party insurance Co.: _____ Insured's Name: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Claim Number: _____ Claims Adjuster's Name: _____ Phone: _____

Attorney Information:

Name: _____ Firm: _____ Date Retained: _____

Contact Person: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

Missed Appointments:

A 24-hour notice is necessary for canceling appointments to be fair to our other patients and staff. Missed appointments or late cancellations will not be billed to your insurance; you are accountable for covering these costs. Please ensure payment is made prior to your next appointment.

Responsibility of Payment:

After confirming your insurance coverage, we will bill your insurance provider directly and accept payment from them. Your signature below confirms your responsibility for covering all services not covered by insurance. If the insurance company denies or partially covers the payment, you will be responsible for the remaining balance.

Release of Medical Records:

By signing below, you are consenting to and instructing the payment of medical benefits for services rendered by the healthcare provider at this office. Additionally, it authorizes permission to share your medical records with your attorneys, healthcare providers, and insurance case managers for claim processing purposes, unless specified otherwise in a separate medical records release signed through your attorney.

Signature: _____ Date: _____