INSURANCE INFORMATION

INSURANCE COMPANY NAME________________________________ PHONE______________

INSURED'S NAME________________________________ PHONE______________

ADDRESS______________________ CITY__________ STATE______ ZIP________

ADJUSTOR__________________ CLAIM#______________ POLICY#__________

HAVE YOU CONTACTED THE INSURANCE COMPANY? YES NO DATE______ WHO DID YOU SPEAK WITH______________

HAVE YOU BEEN CONTACTED BY THE INSURANCE COMPANY? YES NO WHO DID YOU SPEAK WITH______________

OTHER VEHICLE INSURANCE INFORMATION

INSURANCE COMPANY'S NAME________________________________ PHONE______________

INSURED'S NAME________________________________ PHONE______________

DRIVER'S NAME________________________________ PHONE______________

ADDRESS______________________ CITY__________ STATE________ ZIP________

ADJUSTOR__________________ CLAIM#______________ POLICY#__________

HAVE YOU CONTACTED THE INSURANCE COMPANY? YES NO DATE______ WHO DID YOU SPEAK WITH______________

HAVE YOU BEEN CONTACTED BY THE INSURANCE COMPANY? YES NO WHO DID YOU SPEAK WITH______________

GROUP HEALTH INSURANCE INFORMATION

COMPANY'S NAME________________________________ PHONE______________

INSURED'S NAME________________________________ PHONE______________

ADDRESS________________________________ PHONE______________

(IF APPLICABLE) GROUP#______________ POLICY#__________ PLAN#______________

ATTORNEY INFORMATION

ATTORNEY'S NAME________________________________ PHONE______________

ADDRESS______________________ CITY______________ STATE________ ZIP________

ASSIGNMENT OF BENEFITS

I AUTHORIZE PAYMENT OF THE BENEFITS RELATING TO THIS CLAIM TO BE PAID DIRECTLY TO:

I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSINAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE.

PATIENT'S SIGNATURE________________________________ DATE______________