

AUTO/PERSONAL LIABILITY INJURY INFORMATION

Patient Name:	Social Security#:
Date of Injury:	County of Injury:
Type of Injury: Auto Personal Liability	State of Injury:
AUTO Claim Number#: (REQUIRED)	
Automobile Insurance Carrier:	
Billing Address/City/State/Zip (to include 4 digit suffix if known):	
Contact Case Manager/Adjuster's Name: Contact Phone#'s:	
Circle One:	Driver Passenger Other
Auto Insurance:	Full Coverage Coordinates with Health Insurance
Is an attorney involved? Y N	
Attorney Name:	
Attorney Address/City/State/Zip:	
PERSONAL INJURY Claim Number #: (REQUIRED)	
Description of injury:	
Insurance Carrier/Responsible Party:	
Billing Address/City/State/Zip (to include 4 digit suffix if known):	
Contact Case Manager/Adjuster's Name: Contact Phone#'s:	
Is an attorney involved? Y N	
Attorney Name:	
Attorney Address:	
<p>I understand that it is the policy of this office to require written authorization prior to treatment and that it is my responsibility to obtain this authorization. I understand that this provider may bill my health insurance in case of dispute or coordination of benefits, if the auto carrier or liability carrier determines my health insurance is primary. This provider does not have any participating agreements with automobile insurance or liability carriers and I understand that I will be responsible for any unpaid balances.</p>	
Signature:	Date:

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