AUTO ACCIDENT FORM

Patient's Name ________________________ SSN ________________________

Date of Auto Accident ___________________

YOUR Auto Insurance Carrier: Insurance Co. __________________________________

Claim #: __________________________________

Address: __________________________________

____

____

Phone #: __________________________________

Contact Person: ________________________________

In the event I fail to properly file and complete the Auto Accident claim for this injury; or it is determined that the injury or condition is not a result of this auto accident, I understand that I am fully responsible for any and all services rendered.

If I receive a final settlement check, I will contact this office to verify my bill has been paid in full.

This agreement constitutes an acknowledgement of my responsibility.

Signature: ________________________________ Date: _____________________