



AUTO ACCIDENT INSURANCE INFORMATION FORM

www.allstarfitness.com

PATIENT NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CELL#: _____ HOME #: _____ WORK#: _____ DATE OF BIRTH: _____

SS#: _____ DATE OF INJURY: _____ REFERRING DOCTOR: _____

TYPE OF INJURY? (Check all that apply):

AUTO ACCIDENT. If so, did the accident occur in WA state? **YES** **NO.** If NO, what state? _____

JOB RELATED.

PLEASE COMPLETE ALL OF THE FOLLOWING:

WAS THE ACCIDENT YOUR FAULT? **YES** **NO.**

YOUR INSURANCE CO: OR THE CARE YOU WERE IN _____ **INSURED NAME:** _____

ADDRESS OF INS. CO: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE#: _____ ADJUSTER NAME: _____ CLAIM#: _____

AT FAULT PARTY'S INS CO: _____ **INSURED NAME:** _____

ADDRESS OF INS. CO: _____ CITY: STATE: _____ ZIP: _____

PHONE#: _____ ADJUSTER NAME: _____ CLAIM#: _____

ATTORNEY NAME: _____ **CONTACT PERSON** _____

ADDRESS OF INS. CO: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE#: _____ DATE RETAINED _____

PLEASE READ AND SIGN BELOW.:

In fairness to our other patients and to us, 24 hour notice is required for cancellation of an appointment, or you will be charged in full for the time booked.

Once your insurance coverage has been verified, we will be glad to bill directly to and accept payment from the insurance company. It should be understood that all services are charged to you, the patient, who is legally responsible for payment. Patient agrees to pay all collection costs including, but not limited to reasonable attorney fees, late charges and litigation costs in the event of any breach, including failure to timely make any required payments.

I hereby authorize the release of my medical records to the above insurance company for the express purpose of payment for my medical bills incurred in this office.

I hereby authorize the insurance company or attorney to remit payment directly to this office.

SIGNATURE: PATIENT/PARENT/GUARDIAN _____

DATE: _____