



**MOTOR VEHICLE COLLISION CLAIMS INFORMATION**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Date of Accident: \_\_\_\_\_ Number of Vehicles: \_\_\_\_\_  
 Who is At-Fault: \_\_\_\_\_  
 Were you the:     \_\_\_ Driver     \_\_\_ Passenger     \_\_\_ Other \_\_\_\_\_

**In order to be accepted as a patient for your motor vehicle collision we will file all medical bills with your insurance company (first party) so that all bills are paid in a timely manner. Once the first party coverage is exhausted, we will file subsequent claims, if necessary, with the at-fault party's carrier (third party).**

**If this is not agreeable with you, you will need to pay cash for your visit and seek reimbursement from the at-fault party's insurance carrier. There are NO EXCEPTIONS. We will not accept assignment from health insurance carriers for Motor Vehicle Collisions.**

**FIRST PARTY INSURANCE (YOUR AUTO INSURANCE)**

Carrier Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Adjuster: \_\_\_\_\_  
 \_\_\_\_\_ Phone: \_\_\_\_\_  
 \_\_\_\_\_ Claim #: \_\_\_\_\_

**THIRD PARTY INSURANCE (AT-FAULT PARTY INSURANCE)**

Carrier Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Adjuster: \_\_\_\_\_  
 \_\_\_\_\_ Phone: \_\_\_\_\_  
 \_\_\_\_\_ Claim #: \_\_\_\_\_

**ATTORNEY INFORMATION**

Attorney Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 \_\_\_\_\_ Case Manager: \_\_\_\_\_