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Auto Insurance Information Form

Patient Name _____ Date _____

Address_____State____Zip_____

Home #_____Cell/Work #_____Date of Birth_____

SSN_____Date of Injury_____

Did the accident occur in WA state? ☐ Yes ☐ No. If no, what state?_____

Was the accident your fault? ☐ Yes ☐ No

Your Insurance Co. (or the car you were in)_____

Name of Insured_____

Address of Ins. Co._____State____Zip_____

Phone_____Adjuster Name_____Claim #_____

At Fault Party's Ins. Co. _____Name of Insured_____

Address of Ins. Co._____State____Zip_____

Phone_____Adjuster Name_____Claim #_____

Attorney Name_____Contact Person_____

Address_____State_____Zip_____

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Phone_____ Date Retained_____

ALL PATIENTS please read and sign below:

- In fairness to the other patients and the practitioner, 24 hours notice is required for cancellation of an appointment, or you will be charged in full for the time scheduled.
- 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. The 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 payments.
- I hereby authorize the release of my medical records to the above insurance company for the express purpose of payment of my medical bills incurred in this office.
- I hereby authorize the insurance company or attorney to remit payment directly to this office.

Signature_____Date_____