



Dear Patient:

This is information we need to help you get your claim paid by your insurance company. This is also to inform you that if we do not receive payment from your insurance company, within 90 days of the date of service, you will be responsible for the entire amount of the visit. The following are the questions asked by most of the insurance companies:

1. How did the accident occur?

2. When did the accident occur?

3. Where did the accident occur?

4. Was this job related? YES NO If yes, please give details:

5. Was this a Motor Vehicle Accident? YES NO If yes, please give details:

6. Was a third-party responsible? YES NO If yes, give the name and address of the third-party.

Patient Signature: _____ Date: _____