Spellmeyer
CHIROPRACTIC INC.
Life ~ Living ~ Health

MVA ACCIDENT INFORMATION

PATIENT'S NAME _____ DOB_____

DATE OF ACCIDENT _____ STATE ACCIDENT OCCURRED_____

YOUR INSURANCE INFORMATION:

NAME OF POLICY HOLDER _____

POLICY HOLDERS' INSURANCE COMPANY

NAME _____

PHONE NUMBER _____

CLAIMS OFFICE:

ADDRESS _____

PHONE NUMBER _____

CLAIM REPRESENTATIVES NAME _____

CLAIM NUMBER _____

PIP APPLICATION FILLED OUT? YES NO

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I AUTHORIZE SPELLMEYER CHIROPRACTIC INC TO FURNISH MY RECORDS TO THE INSURANCE COMPANY OR AN ATTORNEY FOR THE PURPOSE OF OBTAINING PAYMENT ON MY ACCOUNT FOR SERVICE PROVIDED TO ME. IN ADDITION, THE UNDERSIGNED HEREBY AUTHORIZES PAYMENT DIRECTLY TO SPELLMEYER CHIROPRACTIC INC FOR ALL MEDICAL BENEFITS OTHERWISE PAYABLE TO THE UNDERSIGNED OR THE PATIENT.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED AT SPELLMEYER CHIROPRACTIC INC REGARDLESS OF MY INSURANCE COVERAGE.

YOUR SIGNATURE_____DATE_____

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