

Personal Injury Insurance Form:

Date of Accident: _____ Insurance Company: _____

Patient Name: _____ Insured Name: _____

Adjuster Name: _____ Phone: _____ Ext: _____
Fax: _____

Claims Address: _____

Policy #: _____ Claim #: _____

Notes: _____

CREDIT GUARANTEE AUTO INSURANCE ASSIGNMENT PERSONAL BALANCES

INSURANCE ASSIGNMENT

Our Auto Insurance Assignment Program is designed to render you immediate care and keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your insurance carrier on your behalf and wait up to 3 months for payment. Please remember, however, that you are ultimately responsible for payment. As a prerequisite, we ask that you provide a credit card to guarantee payment of your bill and that you provide us with the following:

Your complete automobile insurance information
Your family health insurance plan information

FILING PROCEDURE

We will submit claims on your behalf to 3rd party payers periodically and at the conclusion of your care.

Any overpayments resulting in credit balances will be refunded promptly at the conclusion of your care.

Balances not paid within 3 months after conclusion of your care will be charged to your designated credit card below. You will be sent a payment voucher. Should settlement be reached prior to the 3 month grace period or should care be terminated for any reason prior to your physician dismissal all balances become due immediately and will be charged to your credit card and are subject to monthly interest charges.

CREDIT CARD: VISA MC DISCOVER

CARDHOLDER NAME _____

CARD # _____ EXP. DATE _____

I agree to the above terms and authorize you to bill the charge card. I understand that should payment not be received within 3 months after termination of my care or should I terminate care before being dismissed by your physician, I will be charged the amount outstanding on my account.

Signature _____ Date _____

PLEASE SIGN OPTION ONE OR TWO:

1. Waiver of Health Insurance Benefits

(USE THIS OPTION IF YOU WANT US TO SUBMIT TO AUTO INSURANCE OR AN ATTY!)

I, _____, the undersigned, do hereby waive health insurance responsibility for all treatment and care arising from my injury, which occurred on _____ (date of injury). I am not filing for health insurance benefits or Medicare and waive their responsibility for one or more of the following reasons:

1. I have not followed my insurance plan's procedure to obtain a referral from my primary care physician to seek services by a participating specialist.
2. I am seeking care from a non-participating health care provider whose care may require the payment of a higher out of pocket co-pay and deductible from me, or whose care may not be covered by my health insurance.
3. Because of the nature of my injuries and/or legal case, I have chosen not to use my health insurance benefits or Medicare to cover any of the health care received as a result of this injury.
4. The law does not require health care providers to do many of the things that can help prosecute my liability claim. For example, the law does not require doctors to take attorney telephone calls, to meet with the lawyer prior to depositions, or to provide records and reports not otherwise required by law. These and many other courtesies, which can help my case, take valuable billable time away from the doctor. I am asking the doctor, of my own free will, to extend these types of courtesies. I understand the doctor may charge for these extra matters. In return, I am agreeing to waive my health benefits, as outlined below. This health care provider may act in complete reliance upon my waiver, in taking actions that it would otherwise not take. The significant benefits I receive from this agreement constitute the consideration necessary to enforce this agreement. These are my wishes.

I agree and understand that I am accepting responsibility to pay for any services rendered herein. I am instructing my health care provider not to file any claims for benefits with my health insurance plan for treatment relating to or arising from the injuries I sustained in this accident. This decision is being made freely and voluntarily by me, without interference or pressure from others, and is made with the understanding of the responsibilities, which arise therefrom.

Patient Signature

Date

2. Refusal to Waive Health Insurance Benefits

(USE THIS OPTION IF YOU WANT US TO SUBMIT TO YOUR HEALTH INSURANCE, NOT AUTO INS. AND NOT AN ATTY.)

I, _____, have instructed Loebig Chiropractic to file the bill for this automobile accident with my health insurance company.

However, I understand the doctor will NOT assist in the accident case in any manner, other than that required by the law.

Automobile accident cases require a significant amount of additional work, time, and expense. I understand the health insurance company will NOT pay the doctor for any of the additional work involved in the accident case.

I understand that the doctor will NOT provide my attorney with any courtesies not legally required, since the doctor will not be paid for this extra work. This provider has made it clear that it is ready and willing to submit this claim to my health insurance company.

Patient Signature

Date

Assignment and Authorization
(To be signed by both the patient and
attorney/insurance adjuster)

You are hereby authorized to disclose and/or furnish my attorney(s) and/or auto-insurance company with any and all medical information, bills, and/or records in your possession which they request in reference to any illnesses and injuries which I have suffered.

I further, irrevocable assign to you, and authorize and direct said attorneys/insurance adjusters to pay from the proceeds of any recovery in my case all reasonable fees for result of the injury or condition heretofore mentioned. I understand that this in no way relieves me of my personal primary obligation to pay for such services and that the signing of this form does not prohibit customary billing by you. All bills shall be paid promptly in the usual manner. This specifically includes but is not limited to any and all Pip, Med-pay, or Med-expense payments.

It is further understood that there is a Statute of Limitations applicable to any civil claim you may bring. In view of this, I hereby agree that the Statute of Limitations with respect to any claim for services mentioned above will not begin until I send you a denial, in writing, of any outstanding balance. Said written denial must be mailed certified mail, return receipt requested, and said return receipt will be required to show proof of the notice of this denial.

Patient Signature

Date

Witness: _____

Date: _____

The undersigned attorney/adjuster for the patient referred to above hereby agrees to comply fully with the foregoing "Authorization and Assignment" and agrees to advise the named assignee in writing the status of the claim of the patient within ten days of the request, and agrees to notify the assignee if the attorney/adjuster ceases to represent this patient and/or if the claims is dropped or denied.

Attorney or Insurance Adjuster Signature

Date