**Auto Injury Patient Questionnaire and Acknowledgement**

Revised 11/2023

Please fill this form in as completely as possible. Any missing information could delay the processing of your claims.

**Patient to select one of the following below options:**

* **Option 1: Insurance**
  + Bill Auto Insurance primary and medical insurance secondary and/or tertiary (if applicable)
  + Any balances remaining after the insurance is billed will be patient responsibility and will not be eligible for attorney/LOP coverage.
  + Please complete insurance information sections on page 2 and provide insurance card(s) to ensure accurate and timely billing.
* **Option 2: Self-Pay**
  + I will pay the self-pay discounted rate (flat fee) at each visit. No insurance or attorney will be involved or billed.
* **Option 3: Attorney/LOP**
  + Patient is represented by an attorney. The attorney will be billed for services provided and I will receive notification f these balances on a regular basis.
  + Please complete Attorney Information on page 2.

I have selected the above option for billing the care related to my MVA and acknowledge and understand the following:

* I will be responsible for all out-of-pocket expenses at the time of my service.
* Any unpaid expenses not covered under an attorney LOP will be included in the balance due and will be my personal responsibility.
* Failure to inform the clinic of changes in my legal representation or insurance coverage may result in all charges becoming my personal responsibility.
* If an LOP is obtained during an episode of care I may elect to change my billing preference for future dates of service. Any services previously billed to insurance cannot be retroactively covered by an attorney/LOP.

**Patient/Guardian Signature:** **Date:**

**Auto Injury Patient Questionnaire**

**Date of Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State of Accident: \_\_\_\_\_\_\_\_\_\_**

**Patient Auto Insurance Information**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Auto Insurance Name: Name of Insured: DOB of Insured:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Number Group Number Claim Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims Adjuster Adjuster Phone Adjuster Fax

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adjuster Street Adjuster City Adjuster State & Zip

**Patient Primary Health Insurance Information**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Health Insurance Name Name of Subscriber DOB of Subscriber

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Number Group Number

**Patient Secondary Health Insurance Information**

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Patient Health Insurance Name Name of Subscriber DOB of Subscriber

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Number Group Number

**Patient Attorney Information**

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Attorney Name Attorney Phone Attorney Fax

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attorney Street Attorney City Attorney State & Zip