perlmanclinic++

Auto Claims Registration Form

Legal Name: Last First Middle	Date of Birth:
Date of Accident:	Time of Accident:
Name of Auto Insurance:	
Policy Holders Name:	Policy Number:
Relationship to Patient: ☐Spouse ☐Parent/Guardian ☐Friend ☐Other_____	
Adjusters Name :	Phone Number: Fax Number:
Adjusters Email:	
Claims Address: Address City State Zip	

Patient Financial Responsibility Policy

Auto Claims: In order to bill claims to Auto insurance, we must have all available information at time of service. This includes but is not limited to the name of the auto insurance, contact information for the adjuster, claims address, claim number, authorization number, policy number, name of the policy holder, date and time of accident. If this information is not provided or available, we will see you on a cash pay basis.

Acknowledgement and Agreement:

I have entered all information to the best of my knowledge and verify the information to be accurate and true. I have read and understand the Patient Financial Responsibility Policy. I also understand that Perlman Clinic may amend such terms from time-to-time. I authorize my Auto insurance benefits to be paid directly to Perlman Clinic. I also authorize Perlman Clinic and my insurance company to release any information required to process my claims.

Printed Name of Patient _____ Relationship to Patient: Self ☐ Other_____

Signature _____ Date _____

If you are not the patient and have not already provided the information below, please complete the following:

Print Your Name: _____

Your Date of Birth: _____

Your Social Security #: _____