## General Information

The amount of paperwork involved in Personal Injury Claim is rather extensive. However, once completed, billing for your account usually runs smoothly. Thank you for your cooperation. If you have any questions, please ask our staff for assistance.

***MASSACHUSETTS LAW***

Medical claims for the treatment you receive is paid by the Personal Injury Protection (PIP) portion of the policy of the **VEHICLE YOU WERE RIDING IN**. We request a copy of of the **COVERAGE SELECTION PAGE** and a copy of the ACCIDENT REPORT for our file to help expedite the processing and payment of your claims.

Your Name:_____ Date of Accident:_____

Town/City/State where the accident occurred:_____

## Personal Injury Insurance Information

Name of insured person whose vehicle you were riding in: _____ Relationship:_____

Their address: _____ City:_____ State:_____ Zip:_____

Name of the above insured's Automobile Insurance carrier:_____ Phone #:_____

Address:_____ City:_____ State:_____ Zip:_____

Have you reported your injury to this insurance company?_____ When was it reported?_____

Personal Injury Protection Claim #_____ What is the adjuster's name?_____

Have you received an application for Personal Injury Benefits from the ins. company?_____ Please complete, **keep a copy** and mail it back to them ASAP. Please provide a copy with a copy of the coverage selection page.

IMPORTANT- Amount of deductible chosen if any under "Personal Injury Protection" portion of Automobile policy: $_____

Name of your Health Insurance Company: _____

Address:_____ City:_____ State:_____ Zip:_____

Phone#:_____ Name of insured:_____

Insured's ID #:_____ Insured's Birthday:_____ Relationship to insured:_____

## Bodily Injury Carrier Information

If the driver of your vehicle was not at fault in the accident, the other party's insurance carrier is called the Bodily Injury Carrier in this situation. This carrier may be held responsible to pay your balance due if your own insurance denies paying the full benefits. Please provide this information so that we may look to them for your unpaid balance (if that is necessary at the end of your treatment) before we look to you.

Name of the person driving the other vehicle involved:_____

Name of their Auto Insurance Carrier:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone #:_____ Claim #:_____

Have you retained an attorney for this accident? ____ Attorney's Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone #:_____ Fax #:_____

## Assignment and Release

Our office is willing to accept your insurance assignment as soon as your coverage is verified. It must be understood that your insurance contracts are between you and your insurance carriers. Our office does not guarantee that your Insurance companies will pay all of your bill. You are required to sign a "Lein" on your first visit. This Lien authorizes payment for services rendered to be issued directly to this office. IF FOR ANY REASON YOUR CLAIMS ARE DENIED BY YOUR INSURANCE CARRIERS, YOU ARE ULTIMATELY & FULLY RESPONSIBLE FOR YOUR BILL.

PLEASE PHONE AHEAD IF YOU ARE UNABLE TO MAKE A SCHEDULED APPOINTMENT. If you are treating for a Motor Vehicle accident and continually fail to make scheduled appointments, you will be discharged. If you have been out of work it will be assumed that you are no longer disabled and are fully able to return to work.

Patient's Signature:_____ Date:_____

Doctor's Signature:_____ Date:_____