concept | CHIROPRACTIC + REHAB

MOTOR VEHICLE ACCIDENT INFORMATION

MOTOR VEHICLE ACCIDENT/PERSONAL INJURY (IF APPLICABLE)		
Date of Accident:	What State did the accident occur in?	
Have you reported the accident to your auto insurance company? ☐ Yes ☐ No If yes, when?		
Have you field a PIP or NO FAULT application with your auto insurance carrier? ☐ Yes ☐ No		
Do you have an open or pending case with them? ☐ Yes ☐ No		
Were you the driver of the vehicle you were in? ☐ Yes ☐ No		
Was the vehicle you were in at fault? ☐ Yes ☐ No		
Have you received any other medical treatment for injuries related to this accident? ☐ Yes ☐ No		
Your Auto Insurance Carrier's Name:	Policy Number:	
Claim Number #:	Adjuster's Name:	Phone #:
3rd Party Auto Insurance Carrier's Name:	Policy Number:	
Claim Number #:	Adjuster's Name:	Phone #:
Do you have an attorney? ☐ Yes ☐ No If yes, Name and Phone #: If no, would you like for us to recommend one?		

By signing below I confirm that the information provided above is true to the best of my knowledge. I understand that I may be billed administrative and filling fees for withholding information as it relates to my medical history or insurance coverage.

I understand that Concept Chiropractic and Rehab will submit claims on my behalf to the appropriate insurance carriers using the information I have given them. I am aware that if my treatment is related to an auto accident or work comp injury it is my responsibility to also adhere to the guidelines for my Major Medical insurance so that in the event my personal injury case closes, my health insurance will be billed and I will be responsible for any co-payments, deductibles or non-covered services.

Print Name _____ Signature (Parent/Guardian if patient is a minor) _____ Date _____

Witness Signature _____ Date _____

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