AUTOMOBILE ACCIDENT CLAIM INFORMATION

PATIENT NAME____ ACCIDENT DATE______________

DRIVER___________ PASSENGER_______ STATE ACCIDENT OCCURRED IN___________

COMPLETE THE FOLLOWING INFORMATION FOR THE VEHICLE YOU WERE IN:

INSURED NAME__________________________________ INS AUTO CO NAME________________

INS CO ADDRESS_______________________________________ INS CO TELEPHONE__________

CITY________________________________ WI_________ ZIP______________________

POLICY NUMBER__________________________ CLAIM NUMBER_____________________

COMPLETE THE FOLLOWING INFORMATION FOR THE OTHER VEHICLE:

INSURED NAME__________________________________ INS AUTO CO NAME________________

INS CO ADDRESS_______________________________________ INS CO TELEPHONE__________

CITY________________________________ WI_________ ZIP______________________

POLICY NUMBER__________________________ CLAIM NUMBER_____________________

I AUTHORIZE *BRONSTON CHIROPRACTIC CLINIC* TO RELEASE MY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I HEREBY AUTHORIZE AND DIRECT THE ABOVE REFERENCED COMPANY (S) TO PAY TO *BRONSTON CHIROPRACTIC CLINIC* SUCH SUMS AS MAY BE DUE FOR SERVICES RENDERED ME BY REASON OF THE ACCIDENT AND TO WITHHOLD SUCH SUMS FROM ANY SETTLEMENT, JUDGEMENT OR VERDICT AS MAY BE NECESSARY TO ADEQUATELY PROTECT AND FULLY COMPENSATE *BRONSTON CHIROPRACTIC CLINIC.* I REQUEST THAT PAYMENT BE MADE DIRECTLY TO SAID CLINIC. THIS IS A DIRECT ASSIGNMENT OF MY BENEFITS UNDER THIS CLAIM.

SIGNED____ DATE_________________________

IF YOU ARE ALSO COVERED BY HEALTH INSURANCE, PLEASE COMPLETE THE FOLLOWING:

INSURANCE CO NAME_________________________________ TELEPHONE_________________

ADDRESS____

CITY________________________________ STATE____________ ZIP_______________

INSURED NAME___________________________ ID#_____________________ GROUP#__________

I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE ABOVE NAMED INSURANCE COMPANY AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE BENEFITS PAYBALE FOR RELATED SERVICES. I AUTHORIZE PAYMENT OF BENEFITS DIRECTLY TO: *BRONSTON CHIROPRACTIC CLINIC.* I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR THE UNCOVERED OR UNPAID PORTION OF MY BILL. THIS AUTHORIZATION IS IN EFFECT UNTIL I CHOOSE TO REVOKE IT.

____ _________________________________

SIGNATURE DATE

ARE YOU REPRESENTED BY AN ATTORNEY? YES NO IF YES, PLEASE COMPLETE THE FOLLOWING:

ATTORNEY NAME___________________________ TELEPHONE ________________

ADDRESS____

CITY____________________________ STATE__________ ZIP_____________

I HEREBY AUTHORIZE *BRONSTON CHIROPRACTIC CLINIC* TO FURNISH MY ATTORNEY WITH A FULL REPORT OF THE EXAMINATION, DIAGNOSIS, TREATMENT, ETC. OF MYSELF IN REGARD TO THE ACCIDENT IN WHICH I WAS INVOLVED.

IF HEREBY AUTHORIZE AND DIRECT MY ATTORNEY TO PAY DIRECTLY TO *BRONSTON CHIROPRACTIC CLINIC* SUCH SUMS AS MAY BE DUE FOR SERVICE RENDERED ME AND TO WITHHOLD SUCH SUMS FROM ANY SETTLEMENT, JUDGEMENT, OR VERDICT AS MAY BE NECESSARY TO ADEQUATELY PROTECT AND FULLY COMPENSATE SAID CLINIC. I HEREBY FURTHER GIVE A LIEN ON MY CASE TO *BRONSTON CHIROPRACTIC CLINIC* AGAINST ANY AND ALL PROCEEDS OF MY SETTLEMENT, JUDGEMENT OR VERDICT WHICH MAY BE PAID TO MY ATTORNEY, OR MYSELF, AS THE RESULT OF THE INJURIES FOR WHICH I HAVE BEEN TREATED.

SIGNED____________________________________ DATE__________________________

I FULLY UNDERSTAND THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO *BRONSTON CHIROPRACTIC CLINIC* FOR ALL MEDICAL BILLS SUBMITTED FOR SERVICE RENDERED ME. I FURTHER UNDERSTAND THAT SUCH PAYMENT IS NOT CONTINGENT ON ANY SETTLEMENT, JUDGEMENT, OR VERDICT BY WHICH I MAY EVENTUALLY RECOVER SAID FEES.

SIGNED____________________________________ DATE__________________________