AUTO ACCIDENT AND PERSONAL INJURY

Please Print

PATIENT'S NAME: ________________________ DATE OF BIRTH: ______________________

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Insurance Company: ____

Address: ____

Claim Number: _________________________ Adjuster Name: _________________________

Phone Number: __________________________ Date of Accident: ________________________

Was the injury reported to the local authorities? ___ NO ___ YES

Briefly describe the accident and injuries: ____

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If you have an attorney, please provide name, address and telephone number: (This is for our chart information only; we will not bill your attorney for services rendered.)

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I understand that my Delaware Neurosurgical Group, P.A. providers are entitled to be paid for services rendered. In the event of a legal settlement, I agree that any "paid" health insurance claim will subrogate back to my health insurance provider. All balances due to Delaware Neurosurgical Group, P.A. for services performed will be paid by my legal representative, regardless of the amount paid by my health insurance provider or any adjustments made to payments based on contractual agreements with my health insurance provider.

In the event my claims are denied by the above listed insurance carrier, I understand my personal health insurance will be billed. Therefore, for my protection, I will obtain the necessary referrals if applicable. I understand that I am responsible for any payment of all services rendered should my claims be denied.

SIGNATURE: ______________________________ DATE: ____________________________

Electronically Signed (if applicable)