MVA / PIP Accident Intake Form

Name:_____Date:_____

Address: _____State_____Zip_____

Phone #_____ Date of Birth: _____

Date of Injury/Accident:_____ What State did the accident take place?_____

Describe what happened?_____

_____

_____

To what extent does this problem interfere with your daily activities? (work, sleep, recreation)

_____

_____

_____

Insurance Company Name (yours) : _____

Phone#:_____ Insurance Co:_____

Claim #:_____Insurance Adjuster: _____

Regarding Insurance:

I authorize my personal injury protection benefits and the liable insurance company to make payments for services rendered directly to Source Wellness Center, PLLC. I understand that if for ***any reason*** *services are not covered by the liable insurance company that any amount due is* ***MY PERSONAL FINANCIAL RESPONSIBILTY*** *and agree to pay any balance, including interest accrued.*

Interest Statement:

Personal injury third party claim (auto accidents or other miscellaneous injury) accounts with Source Wellness Center, PLLC will be paid by the insurance company that is liable for the accident or injury directly to Source Wellness Center ,PLLC. Due to the length of time involved with settling these cases, any balance over 60 days will be charged interest at 12% per annum. This will also be paid at the time of settlement out of the settlement proceeds directly to Source Wellness Center, PLLC. Personal Injury protection subrogation shall be the responsibility of the third party to reimburse to these carrier(s) at the time of settlement.

Guarantee of Payment:

For all third party claims, a guarantee of payments must be signed by both the client and the attorney handling the claim and returned to Source Wellness Center, PLLC prior to receiving treatment services related to said claim. Should there be no attorney, patient must sign an authorization and assignment of benefits and it is the right of the clinic to request payment on account.

I have read the above information. I understand this policy and agree to its terms.

Patient Name: _____ Date:_____

Patient Signature: _____ Date: _____

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