Parker Family Care

MOTOR VEHICLE ACCIDENT FORM

As a courtesy to our patients, PFC will bill auto insurance in the case of an automobile accident claim. In order to do so, all of the following information must to be provided **prior to being seen by a provider**:

Patient's Name_____ **DOB**_____

Automobile Insurance Company Name_____

Address to send Claim

_____

_____

Claim Adjustor's Name_____

Claim Adjustor's Phone Number_____

Date of Injury_____

Claim Number_____

Due to insurance requirements, when a patient is being seen by a provider regarding a motor vehicle injury, the patient will not be able to be seen for any other medical issues. This includes but is not limited to, vaccines, flu shots, and inquiries about symptoms of illness. The patient must schedule another visit to discuss these issues and alert the office **at the time of that the visit** that their health insurance will need to be billed. _____ **Initials**

I acknowledge that I have read and understood the above information. I also agree that I am responsible for any and all payments for service that the automobile insurance does not cover.

Patient's Signature_____**Date**_____