Insurance Information

PATIENT'S OR DRIVERS' AUTO INSURANCE:

NAME OF INSURANCE COMPANY:____

NAME OF INSURED:____

INSURANCE ADDRESS: ____

INSURANCE PHONE:_________________POLICY #:____________________CLAIM#:______________

ADJUSTER NAME & PHONE #:____

THIRD PARTY INSURANCE: (OTHER PARTY INVOLVED IN THE ACCIDENT)

NAME OF INSURANCE COMPANY:____

NAME OF INSURED:____

INSURANCE ADDRESS:____

INSURANCE PHONE:_________________POLICY#:____________________CLAIM#:______________

ADJUSTER NAME & PHONE#: ____

ATTORNEY:

NAME:____

ADDRESS:____

PHONE:____

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I ____________________ GIVE ELK GROVE CHIROPRACTIC CENTER PERMISSION TO PROVIDE MY INSURANCE COMPANY, ATTORNEY OR THIRD PARTY INSURANCE COMPANY WITH MEDICAL INFORMATION AS A RESULT OF MY INJURY ON ______________.

I ____________________ AM AWARE THAT IF I DO NOT HAVE PRIVATE MEDICAL INSURANCE, MEDICAL COVERAGE ON MY AUTO, OR A THIRD PARTY INSURANCE COMPANY THAT IS RESPONSIBLE FOR MY MEDICAL BILLS. I AGREE TO PAY ELK GROVE CHIROPRACTIC CENTER FROM ANY SETTLEMENT RECEIVED AS A RESULT FROM THE INJURY ON ___________________________.

SIGNATURE:_______________________________ DATE:_________________________