# INJURY REPORT

**We have agreed to treat you for your injury and will bill your:**

**Motor Vehicle Insurance ☐** **Other Accident insurance ☐**

**Prior to treatment and or further treatment the following information is needed. Please note: All areas must be completed.**

Patient Name:________________________________________ Date of Accident: _________________________

State the Accident occurred:____________________________

1. Where is your Injury:___________________________________________________________________________
   ____________________________________________________________________________________________

2. Explain in detail how you injury occurred:______________________________________________________
   ____________________________________________________________________________________________
   ____________________________________________________________________________________________
   ____________________________________________________________________________________________
   ____________________________________________________________________________________________

3. Date the injury was reported to the insurance company who will pay the bill:______________________________

4. Insurance Company Name: _____________________________________
   Address: _____________________________________
   _____________________________________
   Telephone Number: _____________________________________
   Claim #: _____________________________________
   Contact Person's full name: _____________________________________

*****Failure to comply will result in you, the patient, being responsible for payment in full.*****

**In addition, I agree I am responsible to notify this office immediately if there is a change in claim status or an Attorney is retained by me. If my claim is denied I understand that the office will need a letter of denial from the insurance so they can bill my health insurance.**

**I understand that when this claim is settled I must still pay the balance in full on my account if the check is sent to me.**

__________________________________________________ ________________________________________

Patient/Guardian Signature Date