ACCIDENT/INCIDENT REPORT FORM

If you have been injured due to a Work Injury, Auto Accident or any other type of Injury, you must provide the below requested information.

Charges will not be submitted to your Worker's Compensation carrier or Auto carrier or Medical Insurance unless the requested information is provided.

We will file your claims, but if we are not paid within 90, **all charges will be your responsibility**.

Patient Name: ____

Patient Date of Birth: ______________________________

ACCIDENTAL INJURY CLAIM FORM

Date of accident: _____________________________

Did this accident happen at work? Yes ( ) No ( )

If so, are you willing a Worker's Compensation claim? Yes ( ) No ( )

If yes, who is your Worker's Compensation carrier?: ____

Address of Worker's Comp carrier: ____

Worker's Comp claim number: ____

Name of the adjuster handling your claim: ____

Is this injury due to an Auto Accident? Yes ( ) No ( )

If yes, please provide the name and address of the Auto Insurance to be billed:

Name of Auto Insurance:_________________________ Address: ____

Claim number assigned to this Auto Accident: ____

Adjustor Name: ____

Relationship to the Policyholder: ____

Primary Policyholder: Spouse _____________________________________ Male ( ) Female ( )

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, are my responsibility.

I authorize my insurance benefits be paid directly to Algimantas S. Kerpe, M.D.

I authorize Algimantas S. Kerpe, M.D. to release pertinent medical information to my insurance company when requested, or to facilitate payment of claim.

Signature of claimant/patient, guardian or authorized representative

____ Date: ________________________________

Printed Name of claimant/patient, guardian or authorized representative

____ Relationship: ___________________________