

Dr. Alice Charap  
Chiropractor  
254 Church St.  
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(415) 863-4424

**PERSONAL INJURY MEDICAL REPORT & INSURANCE INFORMATION**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Location: \_\_\_\_\_

Did you receive first aid or other treatment before coming to our office?

First aid: Yes  No  Treatment: Yes  No

If yes, please describe (date/practitioner/other details): \_\_\_\_\_

Were you hospitalized? Yes  No

Name of Hospital: \_\_\_\_\_ Period of Hospitalization: \_\_\_\_\_

Were x-rays taken? Yes  No  If yes, by whom? \_\_\_\_\_

Patient's Account of Accident: \_\_\_\_\_

\_\_\_\_\_

Patient's Complaints: \_\_\_\_\_

\_\_\_\_\_

**PATIENT'S INSURANCE INFORMATION**

*This information is REQUIRED EVEN IF YOU ARE NOT AT FAULT. If you were a passenger, please fill in the following information for the driver of the car you were in.*

Name of Insured: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_

Claims Address: \_\_\_\_\_

\_\_\_\_\_

**OTHER PARTY'S INSURANCE INFORMATION (IF APPLICABLE)**

Name of Insured: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_

Claims Address: \_\_\_\_\_

\_\_\_\_\_

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### FINANCIAL AGREEMENT FOR PERSONAL INJURY

We would like to welcome you to our office and assure that you will be receiving the best care for your injury.

If you were in an automobile accident, as a courtesy, we will bill your automobile insurance medical payment portion (MedPay). If you were a passenger in a car involved in an accident, we will only bill the insurance of the driver of the car you were in. **In both cases it is necessary that you have the insurance information and know that there is MedPay coverage.**

If you retain an attorney, we may establish a lien upon consideration with your attorney for future settlement with the parties involved should you use up the medical payment portion of your automobile policy related to this accident.

In reading and signing this agreement, you authorize us to bill your automobile insurance for services received in this office for treatment related to your accident. You also acknowledge and understand that you are directly and fully responsible to this office for all bills submitted for services provided related to your accident. **You are ultimately responsible for all treatment fees.**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_