McKinley
Orthopedic & Sports Medicine

AUTO POLICY INFORMATION

PATINET NAME: ____

DOB: ________________________ PHONE #: ______________________

INFORMATION REQUIRED TO BILL AUTO INSURANCE:

DATE OF ACCIDENT: ____

CLAIM NUMBER: ____

AUTO INSURANCE CARRIER: ______________________________________

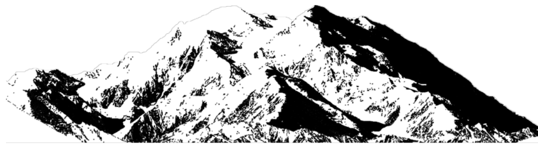
CONTACT PERSON: _____________________ PHONE #: ________________

ARGEEMENT

The Undersigned hereby agrees to supply McKinley Orthopedic & Sports Medicine with the above (NEEDED) information within 5 days for the medical services provided to the above-named patient. I understand that I am responsible for all charges related to the auto accident. If this claim is a third-party claim, I will be responsible for 20% at the time of service until the initial visit is paid by the auto insurance. If there becomes a credit on the account, you will be sent a refund. McKinley Orthopedic and Sports Medicine will not accept liens or hold accounts for settlement. We will gladly setup monthly payment arrangements via our autopay system.

**** IN THE EVENT THE ABOVE INFORMATION IS NOT SUPPLIED TO MCKINLEY ORTHOPEDICS & SPORTS MEDICINE WITHIN THE SPECIFIED TIME (5 DAYS) I UNDERSTAND THAT THE ACCOUNT BALANCE WILL BECOME THE GUARANTOR'S IMMEDIATE RESPONSIBILITY ****

Patient/Responsible Party Signature: ______________________ Date: __________



McKinley
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(STAFF ONLY)

AUTO POLICY INFORMATION CONFIRMATION

Please call the Auto insurance to confirm the following information:

SPOKE WITH: ______________________________ PHONE #: ___________________________

MED PAY AVAILABLE: ____

BODY PART EFFECTED: ____

DATE OF ACCIDENT: ____

AUTO INSURANCE CARRIER: ____

CLAIM NUMBER: ____

ADJUSTER NAME: ____

ADJUSTER PHONE: ____

AUTO INSURANCE CLAIMS MAILING ADDRESS:

____

____

Information collected & confirmed by:

X: ____ Date: ______________________________