

Kathryn Tooker, LAc

Acupuncture & Chinese Herbal Medicine

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Auto Insurance Information Form

Patient Name _____ Date _____

Address _____ State _____ Zip _____

Home # _____ Cell/Work # _____ Date of Birth _____

Date of Injury _____

Did the accident occur in WA state? Yes No. If no, what state? _____

Was the accident your fault? Yes No

Your Insurance Co. (or the car you were in) _____

Name of Insured _____

Do you have Personal Injury Protection? (PIP) Yes No

Address of Ins. Co. _____ State _____ Zip _____

Adjuster Name _____ Phone# _____

Claim # _____

At Fault Party's Ins. Co. _____ **Name of Insured** _____

Address of Ins. Co. _____ State _____ Zip _____

Phone _____ Adjuster Name _____ Claim # _____

Attorney Name _____ **Contact Person** _____

Address _____ State _____ Zip _____

Phone _____ Date Retained _____

ALL PATIENTS please read and sign below:

In fairness to the other patients and the practitioner, 24 hours notice is required for cancellation of an appointment, or you will be charged in full for the time scheduled.

Once your insurance coverage has been verified, we will be glad to bill directly to and accept payment from the insurance company. It should be understood that all services are charged to you, the patient, who is legally responsible for payment. The patient agrees to pay all collection costs including, but not limited to reasonable attorney fees, late charges, and litigation costs in the event of any breach, including failure to timely make any payments.

I hereby authorize the release of my medical records to the above insurance company for the express purpose of payment of my medical bills incurred in this office.

I hereby authorize the insurance company or attorney to remit payment directly to this office.

Signature _____ Date _____