BACKFIT HEALTH + SPINE

Personal Injury Insurance Information

Patient Name: ____________________________ Today's Date:_______________
Date of Accident: __________________________ □ Driver □ Passenger

Please provide as much information as possible so your case can be set up to your financial advantage. In the state of Arizona, insurance laws read that you have the right to bill any insurance policy under which you have coverage. In the case of more than one insurance coverage, overpayment may occur. We need only to be paid once, so all overpayments will be reimbursed to you at the time all payments are received.

<u>Primary Insurance</u> (Health Insurance that covers you)
Do you choose to use your health insurance? _____ If yes, please contact your health insurance immediately and complete the information below.
Insured Name: ___________________________Insurance Name:____________________________________
Insurance Address:______________________________________ Insurance Phone #: __________________
ID #: ___________________________________Group #:____

<u>Medical Payment Coverage:</u> On your automobile insurance, or the automobile insurance for the car in which you were a passenger, there may be coverage called "Med-Pay". This coverage is for any injuries that may have occurred to someone in the automobile. It will cover anything from an automobile accident that either was or wasn't your fault, to slamming your finger in the car door. Using this portion of the policy cannot raise your premium or affect your record in any way. In fact, this is exactly why you pay for "Med-Pay" on your insurance policy. Do you choose to use your med-benefits?_____
Policy Holder's Name: ______________________ Insurance Name: ________________________________
Insurance Address: ____Insurance #:______________________
Policy #: _______________________________Claim #:____

<u>Third Party Liability:</u> This is the insurance information for the person who was in the "other car". The information can be found on the Accident Report.

Driver's Name: ________________________ Driver Address:______________________________________
Policy Holder's Name: ____
Insurance Name: ________________________ Insurance Phone #: __________________________________
Adjuster's Name: _______________________ Phone #: ____
Policy #: _______________________________Claim #:____

<u>Attorney Information:</u>
Do you have an Attorney?_____ If no, we can provide information for an attorney that specializes in Auto Claims.
Name:___________________________________Firm:____
Contact Person:__________________________Ph. #:____

By signing below, I acknowledge that I have provided all the requested information to the best of my knowledge and that I understand all of the information explained to me on this form.

____ _______________
Patient Signature Date

1949 W. Ray Rd., #23, Chandler, AZ 85224 Ph: 480-917-1720 F: 480-917-6934 754 S. Val Vista Dr., #105, Gilbert, AZ 85296 Ph: 480-497-2900 Fax: 480-497-2906
5233 E. Southern, #104, Mesa, AZ 85206 Ph: 480-830-2882 Fax: 480-830-2881 2824 E. Indian School Rd., Ste. 5, Phoenix, AZ 85016 Ph: 602-840-0056 F: 602-840-4056