



PERSONAL INJURY PATIENTS (Please read this letter and indicate below how you are requesting our office to file for payment of all treatments pertaining to your current personal injury case.)

We understand that you may have medical insurance, auto insurance and may have retained an attorney to cover the costs of your personal injury case. You must choose one source of payment only for your case. We will not file to more than one insurance or payment source. If your payer status changes at any time during your treatment it is your responsibility to notify our office immediately. If you do not notify us of this change all charges will be your responsibility.

- If you want us to file with your regular medical insurance, we will require your copay or coinsurance be paid at each visit and will file your claim daily with your medical insurance company. Coverage is dependent on your individual plan and terms.
- If you want us to file with Medicare, we must also receive information about your auto insurance carrier. A denial or letter stating that your benefits have been exhausted must be received from the auto insurance carrier before Medicare will pay.
- If you choose your auto insurance we will file claims with them daily and you will receive a statement for any remaining balance once you have been released from care for your current personal injury case. Payment of any remaining balance will be the responsibility of the patient and should be paid in full within 3 months from the date of your release from care for the current personal injury case.
- If you have retained an attorney and request that your charges be filed with that attorney, we will require that your attorney sign an "Attorney Lien" and all claims will be filed with your attorney daily. Should the settlement amount not be acceptable for covering the cost of the treatment received from our office, any remaining balance will be the responsibility of the patient. The attorney payment option is based on the continued agreement with your attorney as indicated in the signed "Attorney Lien".

Please indicate below where you would like us to file your claims. By signing and dating this form you indicate that you understand the above policy and agree to the payment terms and that we will file your personal injury claims with only the company written below.

Please file my claims with: _____

Name of insurance or Attorney

Patient Signature

Date