Motor Vehicle Collision Client Information

Client Name: _____

Address: _____

Phone Number: _____ Work Number: _____

Date of Motor Vehicle Collision: _____ Treating Therapist: _____

Personal Insurance Company

Name of Company: _____

Contract/Policy Number: _____ Certificate/ID Number: _____

Amount of Coverage: $_____ Percentage of Coverage: _____%

Motor Vehicle Insurance Company

Name of Company: _____

Address: _____

Contact/Adjuster: _____

Phone Number: _____ Fax Number: _____

Policy Number: _____ Claim # _____

1) a) "I _____, authorize pt Health to release medical information to my Section B insurer for billing purposes."

Signature: _____ Date: _____

********OR********

b) This is to certify that pt Health has explained the process of Section B to me and I have chosen with full knowledge not to go through the Section B process.

Signature:_____ Date: _____

2) "I _____, consent to the release of information to my employer as it pertains to my injury and my ability to return to work."

Signature: _____ Date:_____

For Office Use Only

Contact Date: _____ Bill Direct: □ Yes □ No

Additional Notes: _____
_____
_____
_____
_____

MVC Contact Inits: _____ Date: _____