TRINITY
CHIROPRACTIC

Today's Date _____

Patient Number _____

Insurance Claim Information
For a Personal Injury Case

1 Insurance Company Responsible for Your Bill ("At fault" company)

Company Name:_____

Company Address:_____ City:_____ State:____ Zip:_____

Name of person handling your case:_____ Phone Number:_____

Fax number:_____ email:_____

Your Claim Number:_____

2 Your Insurance Company:

Company Name:_____

Company Address:_____ City:_____ State:____ Zip:_____

Name of person handling your case:_____ Phone Number:_____

Fax number:_____ email:_____

Your Claim Number:_____ Do you have med pay?_____ If so, how much?_____

3 Do you have a Lawyer?

Firm Name:_____ Lawyer name:_____

Phone Number:_____ Fax Number:_____

4 Consent

I clearly understand and agree that all services rendered to me are charged directly under my name and that I am personally responsible for payment in the unlikely event that my submissions for my Personal Injury are denied.

Print Name:_____ Date:_____

Patient Signature:_____