PIP/THIRD PARTY/ATTORNEY

Today's Date: _____

PATIENT INFORMATION (YOU):

First Name:_____ Last Name:_____

Insurance Company:_____

Adjuster's Name: _____ Phone #: (_____)_____Ext: _____

Claim #:_____ Fax #: (_____)_____

PIP (personal injury protection)? ___yes___no__ Date of Loss: _____ Time: _____am pm

Location of accident: _____

* If no PIP: proof of PIP denial

THIRD PARTY INFORMATION (OTHER PARTY):

First Name:_____ Last Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Insurance Company:_____

Adjuster's Name: _____ Phone #: (_____)_____Ext: _____

Claim #:_____ Fax #: (_____)_____

ATTORNEY:

Name of Firm: _____ Attorney's Name: _____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone #: (_____)_____ Fax #: (_____)_____

WEBBER CHIROPRACTIC
SPORTS CLINIC

Phone: (425) 889-2882 // Fax: (425) 889-0368
10517 NE 38th Pl. Bldg. 11 Kirkland, WA 98033 // info@webberchiropractic.com

Disclosure Regarding Use of Medical Liens:

I understand that for treatment provider by Webber Chiropractic Sports Clinic related to an automobile collision, primary first party insurance is with the Personal Injury Protection (PIP) Insurance for the car I was driving, riding in as a passenger, or struck by as a pedestrian/bicyclist. I understand and authorize Webber Chiropractic Sports Clinic to bill PIP and authorize the release of any information required related to my examination and treatment in accordance with HIPPA privacy regulations.

Should PIP insurance not be available, exhausted or terminated for any reason, I authorize Webber Chiropractic Sports Clinic to bill any applicable health insurance I may have available, subject to any contract Webber Chiropractic Sports Clinic may have with such carrier, and authorize the release of any information required related to my examination and treatment in accordance with HIPPA privacy regulations.

I authorize Webber Chiropractic Sports Clinic to file a medical lien against any applicable third-party insurance settlement pursuant to RCW 60.44.010, et seq. I understand I may then be asked to make minimum monthly payments to any balance owed. I understand and acknowledge that in the event a medical lien is filed, and that if the lien is paid or settled, I will be provided with an original, written Satisfaction of Lien and I am responsible for filing any such Satisfaction of Lien with County Auditor and for paying the filing fee costs associated with filing any such Satisfaction of Lien. I further understand that payment of medical lien, in some circumstances, may not fully pay my outstanding final charges due to Webber Chiropractic Sports Clinic for treatment provided, and I may be required to make additional payment after satisfaction of the lien.

Dated this _____ day of _____, 20_____,

Patient Signature: _____

Date of Collision: _____