BILLING INFORMATION

Responsible Party

Responsible Party's Name _____
Address_____
City_____State_____Zip_____
Responsible Party's Insurance Co._____
Adjustor_____Phone_____
Claim #_____Adjustor_____

Patient

Your Auto Insurance Co._____
Address_____
City_____State_____Zip_____
Adjustor/Agent_____Policy/Claim#_____

Attorney

Attorney Name_____Phone_____
Address_____
City_____State_____Zip_____

Health Insurance

Your Health Insurance_____
Insured_____ID#_____
Insured's Date of Birth_____SSN_____
Address_____
City_____State_____Zip_____

I understand that I may chose to submit medical bills to my health care insurance and that any monies received will be applied towards my balance. I understand that I am ultimately responsible for the full amount of the bill associated with this accident. Furthermore, I understand that should my health care insurance request reimbursement once a settlement through the automobile insurance is made, then I will be responsible for said reimbursement.

_____ _____
Patient's signature Date