CAPITAL MEDICAL CLINIC, LLP

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Motor Vehicle Accident Billing Information

As a courtesy to you, we will file your auto insurance claim. You must provide all necessary information as listed below. If the information is not provided in 2 days, we reserve the right to bill you for all services.

NAME_____ Date of Birth_____

Address_____ Home Phone_____

City/State/Zip_____ SSN_____

State injury occurred in_____ Date of Injury_____

Brief Description of Injury_____

AUTO INSURANCE RESPONSIBLE_____

Accident claim#_____

Address_____ City _____ State____Zip_____

Contact Person_____ Contact#_____

NAME OF LAWYER (if applicable)_____

Address_____ Phone_____

HEALTH INSURANCE_____ ID#_____

- I understand that Capital Medical Clinic will file claims on my behalf.
- I authorize the release of any medical information necessary to process my claims.
- I understand that I am responsible for payment of all services provided to me by this clinic.
- If I am unable to provide all necessary information at this time, I agree to provide it within 2 days of this appointment.

Signature_____ Date_____