crafted touch

lauren@craftedtouch.com • 116 NE 194th St, Shoreline, WA 98155

Auto Accident Insurance Information Form

Patient Name _____ **Date** _____

Parent Name _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home# _(___)_____ **Work #** _(___)_____ **Cell#** _(___)_____

Patient Date of Birth _____ **Date of Injury** _____ **Doctor**_____

Type of Injury (check all that apply): ☐ **Auto accident** ☐ **Work Related**

Accident occurred in WA state? Y N **If not, which one?** _____

Were you determined to be at fault? Y N

Your Insurance Carrier _____ **Insured's Name** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Phone#_____ **Adjuster's Name** _____ **Claim #** _____

At Fault Party's Ins. Co _____ **Insured's Name** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Phone#_____ **Adjuster's Name** _____ **Claim #** _____

Attorney _____ **Contact person** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Phone# _____ **Date Retained** _____

Please read and sign below:

Once insurance coverage has been verified, we will be glad to bill directly to and accept payment from the insurance company. It should be understood that all services are charged to you, the patient, who is legally responsible for the payment. Patient agrees to pay all collection costs including, but not limited to reasonable attorney fees, late charges and litigation costs in the even of any breach, including failure to time make any required payments.

My practice policies include full charge for any missed appointments, and a half-rate fee for late cancellations ($40-60/session – depending on the duration). Cancellations within 24 hours are considered 'late,' such that I often cannot fill that appointment time. (Exceptions may be made for emergencies or sudden illness.) I hope this policy will be fair to all involved, and give me time to see as many people as possible.

Patient/Parent/Guardian: I hereby authorize the release of my medical records to the above insurance company for the purpose of payment for my medical bills incurred in this office. I agree to the fee policies above, and authorize the insurance company or attorney to remit payment directly to this office.

Signature: _____ **Date:** _____