DATE COMPLETED: ________________

ORTHOTIC AND PROSTHETIC SPECIALTIES

Patient Name: __________________________

Date of Birth: ___________________________

AUTO ACCIDENT INFORMATION:

Date of Injury:____________________________

Name of Insured Person:____

Address:____

____

Phone:____

AUTO INSURANCE COMPANY:

Auto Insurance Company:____

Address:____

____

Phone #:____

Auto Insurance Policy #:____

Claim #:____

Auto Insurance Contact Person:____

WE FILE INSURANCE AS A COURTESY TO THE PATIENT. THE OFFICE WILL WAIT 60 DAYS TO HEAR FROM INSURANCE AFTER A CLAIM IS FILED. AFTER THE 60 DAY WAITING PERIOD, THE PATIENT WILL BE RESPONSIBLE AND MAY BE REIMBURSED BY THE INSURANCE COMPANY.

IT IS ALWAYS THE PATIENT'S RESPONSIBILITY TO BE SURE WE ARE GIVEN COMPLETE BILLING INFORMATION. FAILURE TO DO SO WILL RESULT IN THE PATIENT BEING RESPONSBILE FOR ANY BALANCE INCURRED.