Coordination of Benefits & HIPPA Acknowledgment

Dear Patient,

Your insurance contract(s) may provide for benefits to be coordinated with other medical insurance by which you may be covered. In this case, your primary insurance pays first when there is more than one insurance company. Please complete the portions below if applicable.

Section 1

Name of Physician/Provider you are seeing: _____
Is the reason for your visit due to an injury caused by an accident? ☐ Yes ☐ No
If Yes, please indicate the type of accident: ☐ Auto Accident ☐ Work ☐ School ☐ Home
☐ Other Please describe _____
Is a third party responsible for your injury? ☐ Yes ☐ No Who? _____

Section 2 (Please complete if injury is related to an auto accident)

Were you in your own vehicle, or someone else's vehicle? _____
Name of Auto Carrier? _____Adjuster _____
Phone # _____Claim # _____ Date of Injury?_____
Do you have an attorney? ☐Yes ☐ No If yes, who? _____
Attorney phone # _____ Legal aide/contact _____

Section 3 (Please complete if injury is related to a workers comp claim)

Employer at the time of the injury _____
Date of Injury _____ Work Comp Ins. Carrier _____
Adjuster _____ Phone # _____
Case Manager _____ Phone # _____
Do you have an attorney? ☐ Yes ☐ No If yes, who? _____

Please read below and sign.

To the best of my knowledge, the statements above are true. Unanswered questions indicate they do not apply. My signature authorizes my insurance carrier to receive any payment and all information concerning claims filed by me or on my behalf to another insurance carrier for the purpose of coordination of benefits.

My signature also serves as acknowledgement that upon request I will be provided a copy of the HIPPA privacy policy.

_____ _____
Signature Date