STUCKY CHIROPRACTIC

Name: _____ SSN:_____

Phone: _____ Best time to call _____

Have you retained an attorney? □ Yes □ No	Attorney's Name:	Attorney's phone number:	
Attorney's Street Address:	City:	State:	Zip Code:

Auto Owner's Name:			Other Driver's Name		
Auto Owner's Insurance Carrier:			Other Driver's Insurance Carrier:		
Insurance Address:			Insurance Address:		
City:	State:	Zip Code:	City:	State:	Zip Code:
Insurance phone number:			Insurance number:		
Claim #:	Policy #:		Claim #:	Policy #:	
If you were injured in an auto, indicate your status: □ Driver □ Passenger □ Other _____					

Patient Signature _____ Date _____

Please provide as much information as possible when completing this injury report.

We will gladly make a copy of this information upon your request. 12/08

Stucky Chiropractic
2105 E. Clairemont Avenue
Eau Claire, WI 54701
Phone: (715)835-9514
Fax: (715)835-2602

Auto Accident/Personal Injury Financial Policy

It is necessary for you to provide us with accurate and complete account/claim information. As a courtesy, we will submit charges to your insurance. **Ultimately, you are responsible for all charges incurred on your account.**

If you have health insurance benefits, you need to present your insurance card and a photocopy will be made and kept in your file for future submission once your med-pay limit on your auto insurance policy has been exhausted.

We require a minimum $50.00 co-payment for your initial visit and $10.00 co-payment on all subsequent visits. If we are submitting charges to your health insurance you will be expected to make payments according to the benefit information provided to our office. If you suspend or terminate care with our office, we reserve the right to request payment in full immediately regardless of any claims submitted. You will be expected to resolve your balance in full no more than 6 months after your doctor has discharged you from this case unless other arrangements have been made with our office.

If an attorney is representing you, please notify us immediately.

Patient Signature_____Date_____

Witness Signature_____ Date_____

We will gladly make a copy of this information upon your request. 12/08