

Primary Insurance Information

Insurance Carrier Name: _____ Group #: _____

I.D. # _____ Insured Name: _____

Relationship to insured: Self Spouse Other Insured date of birth: _____

Insurance Carrier Telephone #: _____

Address: _____

State: _____ Zip Code: _____

Secondary Insurance Information

Insurance Carrier Name: _____ Group #: _____

I.D. # _____ Insured Name: _____

Relationship to insured: Self Spouse Other Insured date of birth: _____

Insurance Carrier Telephone #: _____

Address: _____

State: _____ Zip Code: _____

WORKERS COMPENSATION OR AUTO ACCIDENT INFORMATION

MY INJURY WAS: Work Related Auto Related Other

Have you notified your insurance company yet? Yes No

Insurance Company: _____ Attorney _____

If work accident: Name of workplace: _____

If auto accident: Name of insured person: _____

Policy/Claim #: _____

Date of Injury: _____

In what state did injury occur? _____

Case Manager/Claim Adjuster: _____

Insurance Billing address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____) _____ - _____

I certify that this information is true. I authorize that payment of any insurance benefits for health care services or goods may be made directly to Vancouver Spine & Orthopedic Rehabilitation. **I understand and agree that I am ultimately responsible for payment.** I acknowledge that I have been given a copy of the Patient Privacy Policy in accordance with the Health Information Portability and Accountability Act of 1996.

Patient's Signature: _____ Date: _____