LIABILITY FORM

PATIENT NAME_____ SSN#_____

DATE OF INJURY**:**_____DATE OF SURGERY:_____

ACCIDENT RELATED? [ ] AUTO [ ] OTHER

STATE IN WHICH AUTO ACCIDENT OCCURRED?_____

LIABILITY INSURANCE COMPANY INFORMATION

LIABILITY INSURANCE CARRIER:_____

CLAIM #_____

POLICY HOLDER_____

ADDRESS_____

CITY:_____ST_____ZIP_____

PHONE_____FAX_____

AGENT/ADJUSTER'S NAME_____

PHONE_____

FAX _____

WAS A POLICE REPORT FILED? [ ] YES [ ] NO

WHO'S FAULT WAS THE ACCIDENT?_____

ATTORNEY'S NAME_____

FOR OFFICE USE ONLY:

AUTHORIZATION FOR PROCEDURES ***DATE /APPROVED BY***

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