Connecticut Spine & Rehab
Injury Relief Centers

MOTOR VEHICLE INTAKE FORM

CARRIER INFORMATION

Insurance Carrier Name: _____ Carrier Phone No. _____

Address: _____

Policy No. _____ Claim No. _____ Date of Accident: _____

Was the accident reported to your carrier? ☐ yes ☐ no

Do you have medical coverage with your auto insurance policy? ☐ yes ☐ no

ATTORNEY INFORMATION

Attorney's Name: _____ Phone No. _____

Address: _____

May we contact your attorney regarding your case? ☐ yes ☐ no

AUTHORIZATION

I, the undersigned, certify that the information given above is correct. I clearly understand and agree that all services rendered to me that are not covered, are charged directly to me, and that I am personally responsible for payment.

Patient's Signature: _____ Date: _____

Please note: In this instance, we will attempt to bill any back-up insurance you may have prior to billing you directly.