MIDWEST NEUROSURGERY ASSOCIATES, P.C.

AUTOMOBILE
NO FAULT OR LIABILITY
INSURANCE INFORMATION

Patient name _____ Today's Date_____

Accident Information

Date of Accident:_____ Type of Accident: ____ Auto ____ Other

Please describe accident (if not auto) _____

Non-auto Accident Insurance Information

Name of Business or Property Owner:_____

Telephone Number: _____

Address: _____

Are you or a family member going to file a liability claim in connection with this injury? Yes___ No___

Complete this section if an auto, premises medical, or liability claim will be filed

Name of policy holder _____ Claim Number_____

Address of policy holder _____

Name of Insurance Company_____

Address of Insurance Company _____

Name of Patient's Legal Representative (if any) _____

Phone number of legal representative _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize payment of auto, premises medical or liability insurance benefits directly to MIDWEST NEUROSURGERY ASSOCIATES, P.A. I consent to the release of information to the insurance company and to my referring physician.

_____

Patient Signature Date

LIABILITY LIEN AUTHORIZATION

I grant Midwest Neurosurgery Associates, P.A., a lien on any and all claims, counterclaims, demands, suits, or rights of action for damages I may have, assert, or maintain against any third party who may have caused injuries for which Midwest Neurosurgery Associates, P. A., provided medical and health care services, for the cost of such services.

_____

Patient Signature Date