HULST JEPSEN
PHYSICAL THERAPY

Auto Insurance Disclosure & Authorization Form

I, the undersigned, represent that I have good and sufficient reason to believe the condition for which I am seeking treatment is covered by automotive insurance. I am providing the information below and hereby authorize **Hulst Jepsen Physical Therapy, Inc** and its' attorneys to make further inquire into the status of my claim.

Automotive Insurance:_____

Auto Insurance Phone Number:_____

Date of Accident:_____ Body Part Injured:_____

Person Authorizing Claim:_____ Phone Number:_____

Claim Number:_____

Is your auto policy coordinated with your health insurance: Yes No Unsure (circle one)

If yes or unsure you must provide us with your health insurance information:

Insurance: _____

Contract Number:_____Group Number:_____

Subscriber Name: _____Subscriber DOB:_____

I understand that **Hulst Jepsen Physical Therapy, Inc** will waive personal responsibility for any amount due unless it is late found that the condition treated was not automotive related, authorized, or if a settlement was reached. If it is determined any amount not covered is due to the above reasons, then I expressly agree to assume responsibility for all amounts due.

_____

SIGNATURE OF PATIENT AND/OR RESPONSIBLE PARTY **DATE**

I agree to the terms presented above and hereby request and authorize **Hulst Jepsen Physical Therapy, Inc** to treat me. I also authorize the release, for medical and/or billing purposes, all information acquired in the course of my treatment.

_____

SIGNATURE OF PATIENT AND/OR RESPONSIBLE PARTY **DATE**