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 (circle one): Yes No Unsure

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 later 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.

By signing below, 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.

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

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