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.

Claim Number: _____

Automotive Insurance Company: _____

Auto Insurance Phone Number: _____

Date of Accident: _____ Body Part Injured: _____

Person Authorizing Claim: _____ Phone 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:

Health Insurance Company Name: _____

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 auto-related, authorized, a settlement was reached, a deductible is required or the maximum benefit has been paid out. 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.

_____

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

_____

PRINTED NAME OF PATIENT AND/OR RESPONSIBLE PARTY