montgomery medical associates, pc

Auto Accident Form

Patient Name: ....

Date of Birth: ....

Date of Incident: .... State of Incident: ....

Claim Number: ....

Insurance Carrier Name: ....

Claim Adjuster Name: ....

Claim Adjuster Phone Number: .... Ext: ....

Claim Adjuster Fax Number: ....

Attorney Name: ....

Attorney Phone Number: .... Ext: ....

Attorney Address: ....

....

....

I hereby authorize Montgomery Medical Associates, P.C. the release of any medical information necessary to process a claim. I hereby assign payment directly to Montgomery Medical Associates, P.C. all payments due from my insurance company and or attorney. I understand that I am financially responsible for the charges are the responsibility of the patient.

Patient Signature: .... Date: ....

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