Somerville Family Practice
1020 Broadway Somerville MA 02144
Phone: 617-628-2160 Fax: 617-628-8237

Motor Vehicle Accident Financial Agreement

Somerville Family Practice wants to assist you with your financial concerns regarding payment for services provided you for injuries you that you have sustained in an automobile accident. If a motor vehicle insurance company is involved, your health insurance is not considered the primary insurance and is subject to subrogation -and/or may not pay your automobile related claims if other insurances are responsible for your injuries. Therefore, in order to assist you in filing all claims applicable to your auto accident please provide the following at your initial appointment; otherwise claims will be bill to you directly:

Date of Accident: __________ Injury's sustained ______________________________

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Patient Insurance Information (Vehicle you were in. A report of bodily injury must be made to this insurance.)

Auto Insurance Carrier: ______________________________

Name of Adjustor: ______________________________

Claim #: ______________ Phone #: ______________ Fax #: ______________

Billing Address: ______________________________

City: ______________________

State: ______________

Zip: __________

Involved Party Information (Other auto involved)

Name (of person in other auto): ______________________________

Involved Party Insurance (A report of bodily injury must be made to this insurance.)

Auto Insurance Carrier: ______________________________

Name of Adjuster: ______________________________

Claim #: ______________ Phone #: ______________ Fax #: ______________

Billing Address: ______________________________

City: ______________________

State: ______________

Zip: __________

Assignment of Benefits I hereby assign and grant the benefits that I am eligible to receive for professional services rendered in this office. I authorize the release of any medical information necessary to process any insurance claims for payment. I understand that I am financially responsible for those charges not paid by my insurance.

Patient Signature: ______________________________ Date: ______________

Printed Name: ______________________________

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WORKERS COMPENSATION FORM

Patient Name: ______________________________ DOB: ______________

Date of Accident: ______________

Employer name: ______________________________

Place of Injury: ______________________________

Type of injury: ______________________________

How did the accident occur? ______________________________

____

Workers Compensation Insurance:

Company______________________________

Address______________________________

City______________________ State________ Zip__________

Telephone: (_____) ______________ Fax: (_____) ______________

Claim#______________

Name of adjuster: ______________________________

Adjuster phone number :(_______) ______________ Ext: __________

If my injury is found not to be work related and is denied by the insurance company and the Industrial Accident Board at Workers' Compensation 1 Congress Street, Suite 100 Boston, MA 02114-2017 Tel: 617-727-4900, I realize that I will be responsible for payment of my bills either through my medical insurance carrier or myself.
I am seeking medical care relating to the diagnosis and treatment of a certain condition which may or may not be work related and as such may or may not be covered by my employee workers compensation insurance company. I acknowledge the matters concerning my condition may be disputed.

I hereby authorize Somerville Family Practice to discuss my medical condition including the diagnosis and treatment, with the appropriate representatives of my applicable employer, my applicable employer's workers compensation insurance carrier and/or representatives of the Industrial Accident Board.

______________________________ ______________
Patient Signature Date

Printed name: ______________________________