INTEGRATED PAIN MANAGEMENT, S.C.

Interventional Anesthesiologist, Pain Medicine, & Physical Therapy

PERSONAL INJURY INFORMATION

PATIENT'S NAME: _____

DATE OF INJURY: _____

PRIVATE INSURANCE:
Please provide a copy of private insurance

INSURANCE COMPANY: _____

POLICY #: _____ **GROUP #:** _____

☐ **YES, I authorize the provider to submit claims thru my private insurance.**
Also hereby authorize payment directly to IPM of the insurance benefits otherwise payable to me but not to exceed the balance of IPM regular charges for services rendered to me. I understand I may be financially responsible for charges not covered by my medical insurance.

☐ **NO, I do not authorize the provider to submit claims thru my insurance.**

PATIENTS AUTO INSURANCE INFORMATION:

INSURANCE COMPANY: _____

TEL. #: _____ **FAX #:** _____

ADDRESS: _____

CLAIM #: _____ **ADJUSTER:** _____

OTHER PARTY AUTO INSURANCE INFORMATION:

INSURANCE COMPANY: _____

TEL. #: _____ **FAX #:** _____

ADDRESS: _____

CLAIM #: _____ **ADJUSTER:** _____

LAWYER'S INFORMATION:

NAME: _____

ADDRESS: _____

TEL #: _____ **FAX:** _____

_____ _____

PATIENT'S SIGNATURE **DATE**

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