

Insurance Statement

Private group health insurance coverage? Yes / No _____
 Circle one Initial here

Personal injury protection (PIP) coverage? Yes / No _____
 Circle one Initial here

Third Party insurance coverage/settlement? Yes / No _____
 Circle one Initial here

I have provided Dr. Brown with the names and policy numbers of all insurance carriers that could be responsible for payment of medical bills related to my injury on _____. (Initial here) _____

I authorize all carriers to divulge PIP amounts, accident reports, and any other related information requested by the office of Dr. Brown.

I authorize payment from personal group insurance, PIP insurance or third party liability insurance to be paid directly to Dr. Brown for services provided by his office.

I understand that assignment of benefits may only be revoked if under written agreement by both the patient and provider or authorized representative of the provider.

I understand and agree that I may be responsible for payment of all related charges if information is withheld or incorrect.

Patient Signature

Date

Provider or representative signature

Date