

Chiropractic Life Center, PC
305 N.W. Englewood Court
Suite: 200
Gladstone, MO 64118
Phone: (816)-454-5433 Fax: (816)-454-8455

Auto Accident Policy

We will file your insurance for you with your automobile carriers, your health policy, and your attorney. YOU ARE RESPONSIBLE FOR PAYMENT OF YOUR ACCOUNT REGARDLESS OF INSURANCE SETTLEMENT. TO FILE CORRECTLY, WE MUST HAVE THE FOLLOWING INFORMATION. REGARDLESS OF WHO CAUSED THE ACCIDENT, WE WILL LOOK TO THE FOLLOWING FOR SETTLEMENT OF YOUR BILL.

PRIMARY SOURCE IS:
MEDICAL PAY ON YOUR AUTO POLICY:

Policyholder: _____

Address: _____

City/State/Zip: _____

Policy #: _____

Insurance Phone #: _____

Insurance Company: _____

Insurance Address: _____

City/State/Zip: _____

CLAIM #: _____

Adjustor: _____

Please continue to next page.

**ADDITIONAL SOURCE IS:
PERSON RESPONSIBLE FOR ACCIDENT**

Policyholder: _____

Address: _____

City/State/Zip: _____

Policy #: _____

Insurance Phone #: _____

Insurance Company: _____

Insurance Address: _____

City/State/Zip: _____

CLAIM #: _____

Adjustor: _____

**WILL ALSO FILE FOR BENEFITS ON
YOUR HEALTH INSURANCE CARRIER;**

Policyholder: _____

Address: _____

City/State/Zip: _____

Policy #: _____

Insurance Company: _____

Insurance Address: _____

City/State/Zip: _____

PHONE #: _____

**Please give front desk your insurance card to copy. We will coordinate benefits with auto carriers.

ATTORNEYS NAME: _____

PHONE #: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

We will work with you on the financial portion of your care. Since you have the contract with your insurance company, they are not responsible to pay us directly. Since neither you nor our office has the policy with the other person insurance, it is not their responsibility to pay us directly. **THEREFORE, it is YOUR RESPONSIBILITY TO SETTLE this bill in full when you are dismissed from corrective care. If you would rather pay as you go to avoid the balance due in a lump sum, set up arrangements with the front desk. I HAVE READ AND UNDERSTAND YOUR INSURANCE FILING PROCEDURE AND PAYMENT RESPONSIBILITY.**

Signature: _____ Date: _____