Universal Injury or Accident Statement

Last Name ______________________________ First Name ____________________________M.I. _________

Is the condition for which you are receiving treatment due to an accident or injury?

______ No

______ Yes

Date of Injury ________/_________/__________

Give a brief description and location of the accident:

____

____

A. **Is the condition for which you are receiving treatment due to a motor vehicle accident?**

_______ No

_______ Yes

B. **Is the condition for which you are receiving treatment due to a work related injury?**

_______ No

_______ Yes (continue with this section)

Name of Employer __________________________________ Phone Number (______) _____________________

Human Resources Contact _________________________________ Phone Number (______) ________________

Workers Compensation Insurance _____________________________________ Claim Number ______________

Adjuster Name___________________________________ Phone Number (______) _______________________

Claim Address______________________________ City______________________ State ______ Zip ________

Is there a possible third party liability settlement? No Yes

If **YES**, complete the following section:

Name of Insurance: _____________________________________ Phone Number: ______________________

Adjuster's Name: ____ Phone Number: ____________________

I certify that this information is true and accurate. I hereby authorize the release of a copy of this form as may be necessary to obtain reimbursement from any insurance company which may request information regarding my injury and the nature of the treatment. I also understand that I am responsible for responding promptly to my insurance carrier if they request any additional information, and that failure to provide requested information may categorize my treatment as a "non- covered" service and may make me personally liable for the medical charges incurred.

Signature____ Date ____________________________