Automobile Accident Questionnaire

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952.314.7035
info@sunuwellness.com

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Minneapolis, MN 55410
612.767.4680
lindenhills@sunuwellness.com

Today's Date: _____

Full Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Secondary Phone: _____

How were you referred to our clinic: _____

Date and Time of Accident/Injury: ____/____/____ ____:____ AM PM

Policy Number: _____

Medical Claim Number: (Not Bodily Claim # - these are different) _____

Your Auto Insurance Company: (not the other driver) _____

Are you the policy holder? Yes No If no, Then the name of the policy holder: _____

Claim Adjuster: _____

Contact Info: _____

Medical Claim Billing Address: _____

Medical Claim Fax Number: _____

Have you retained an attorney? Yes No Not yet

Name of Attorney: _____ Phone: _____

Address: _____

FINANCIAL POLICY REGARDING AUTO ACCIDENTS

Charges incurred for your care will be filed with your delegated worker's compensation company. Each insurance company has their own rules, regulations, limits, and procedures and we will work with your insurance company to try and secure coverage for the care you need. However, we CANNOT guarantee payment. If your account is not settled in-full through your insurance within 90 days following the completion of your treatment, the remaining balance will become the patient's responsibility. At that point we can help to set up a monthly payment plan in order to settle your account balance.

I have read, understand, and agree to the financial policy of SuNu Wellness Center as stated above.

Name (Print): _____

Signature (Required): _____ **Date:** _____