SOUTHWEST DIAGNOSTIC CENTER

AUTO ACCIDENT QUESTIONNAIRE

Name: _____

Date of Birth: _____/_____/_____ Date of Injury: _____/_____/_____

Was the accident your fault? YES NO Were you the driver or passenger?_____

Name and phone number of YOUR insurance company:

_____

Name and phone number of OTHER DRIVER'S insurance company:

_____

Which insurance company are we billing? _____

Claim Number we are using to process your medical claim: _____

Claims Adjuster name and phone number: _____

Are you being represented by an attorney? YES NO

Attorney Name and Phone #: _____

_____

Do you have health insurance? YES NO

Do you want Southwest Diagnostic Center to bill your health insurance? YES NO

(if yes, please give card to receptionist)

Please read and sign:

I understand that if I do not give my health insurance information to Southwest Diagnostic Center, they will not be able to send my medical claim to my health insurance if more than 30 days later, if pre-authorization was not obtained before the date of service or if your health insurance is not accepted by Southwest Diagnostic Center.

If, for any reason, the above-mentioned attorney decides to no longer represent me, it is my responsibility to notify Southwest Diagnostic Center of this change and who my new attorney is. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR MY BILL WITH SOUTHWEST DIAGNOSTIC CENTER WHETHER I AM BEING REPRESENTED BY AN ATTORNEY OR NOT.

I understand if the services provided today are being represented by an attorney, auto insurance and or third party payor, I am financially responsible for all charges incurred.

_____ _____

PATIENT NAME PATIENT SIGNATURE

_____

DATE