Valley of the Sun Institute for Pain Management

Dr. Estelle Farrell

Insurance Waiver

Please review and read carefully

Patient Name:_____ Today's Date:_____
Date of Accident:_____ □ Driver □ Passenger
Policy Holder's Name:_____ Insurance Name:_____
Insurance Address:_____
Insurance Phone #:_____
Policy #:_____ Claim #:_____

Third Party Liability: This is the insurance information for the person who was in the "other car." The information can be found on the Accident Report.
Driver's Name:_____
Driver's Address:_____
Policy Holder's Name:_____ Insurance Name:_____
Insurance Phone #:_____
Adjuster's Name:_____ Phone #:_____
Policy #:_____Claim #:_____

Attorney Information:
Do you have an Attorney? □ Yes □ No
***If no, we can provide information for an attorney that specializes in Auto claims

Name:_____ Firm:_____
Contact Person:_____ Phone #:_____

I , _____ hereby request and consent for Valley of the Sun Institute for Pain Management to bill my Auto/Lien/Lawyer instead of my personal insurance as of today's date . I understand that if my Auto/Lien/Lawyer do not pay for the services rendered by Valley of the Sun Institute for Pain Management, I will be liable and financially responsible for any cost and balances due on my account. I hereby give Valley of the Sun Institute for Pain Management permission to bill me for any services not covered by my Auto/Lien/Lawyer. I understand that all insurances have a timely filing limit to submit claims. If my Auto/Lien/Lawyer do not cover the services rendered and they are outside of the timely filing limit for my insurance to be billed, I understand that I am financially responsible for any amount due on my account. I understand and take full responsibility for understanding and knowing my insurance benefits and limitations. By signing below, I agree that I have requested for my Auto/Lien/Lawyer to be billed instead of my personal

insurance and accept financial responsibility for the cost related to the treatment provided by Valley of the Sun Institute for Pain Management. I give my acknowledgement and consent by signing this document.

_____ _____ _____

Signature of Patient/Parent/Guardian Date Relationship to Patient

Personal Injury Insurance Intake

Patient Name:_____ Today's Date:_____
Date of Accident:_____ □ Driver □ Passenger
Please provide as much information as possible so your case can be set up to your financial advantage. In the state of Arizona, insurance laws read that you have the right to bill any insurance policy under which you have coverage. In case of more than one insurance coverage, overpayment may occur. All overpayments will be reimbursed to you at the time all payments are received.

Primary Insurance (Health Insurance that covers you):
Do you choose to use your health insurance? □ Yes □ No If yes, please contact your health insurance immediately and complete the information below.
Insured Name:_____ Insurance Name:_____
Insurance Address:_____
Insurance Phone #:_____
ID#:_____ Group #:_____

Medical Payment Coverage: On your automobile insurance, or the automobile insurance for the care in which you were a passenger, there may be coverage called "Med-Pay." This coverage is for any injuries that may have occurred to someone in the automobile. Do you choose to use your "Med-Pay" benefits? □ Yes □ No
Policy Holder's Name:_____ Insurance Name:_____
Insurance Address:_____
Insurance Phone #:_____
Policy #:_____ Claim #:_____

Third Party Liability: This is the insurance information for the person who was in the "other car." The information can be found on the Accident Report.
Driver's Name:_____
Driver's Address:_____
Policy Holder's Name:_____ Insurance Name:_____
Insurance Phone #:_____
Adjuster's Name: _____ Phone #:_____
Policy #:_____ Claim #:_____

Attorney Information:
Do you have an Attorney? □ Yes □ No ***If no, we can provide information for an attorney
Name:_____ Firm:_____
Contact Person:_____ Phone #:_____

By signing below, I acknowledge that I have provided all the requested information to the best of my knowledge and that I understand all the information explained to me on this form.

Signature of Patient/Parent/Guardian	Date	Relationship to Patient

Personal Injury Insurance Intake

Lien and Security Agreement

1. **Responsibility for Payment**: You have provided and/or will provide medical services to me. In reliance on this agreement, you are willing to extend the time for me to pay you for medical services rendered or to be rendered. Nevertheless, I understand that if I do not recover on any claim I am asserting as a result of my accident/injuries, I will remain directly responsible to pay you for such services.

2. **Lien and Security Agreement**: In consideration for your awaiting payment for medical services rendered, I grant you a lien against and a security interest in any claim I may have arising from my accident/injuries, together with and direct my attorney to pay to you all sums (including interest) which may then be due to you prior to disbursing any funds to be due to you. I further expressly waive and release any claim of exemption I may otherwise have under federal or state law with respect to the referenced proceeds.

3. **Remedies**: If I default under this Agreement, you will have all rights and remedies of a secured party as well as all other rights and remedies available at law or in equity. Additionally, I will pay all your costs and reasonable attorney's fees incurred as a result of my default.

Patient Printed Name	Date of Birth	Patient Social Security Number

Signature of Patient/Parent/Guardian	Date	Relationship to Patient

We have been contacted by your client stated above regarding injuries they have suffered in the Automobile accident on _____. As attorney of record for the referenced patient, I acknowledge and agree to observe the above-referenced provisions. I understand that you are relying on this Agreement and my Acknowledgement in extending the time for the patient to pay you for your medical services. If I receive proceeds of any settlement, judgement or verdict relating to the patient's claim then, prior to disbursing any such proceeds to the patient or paying my attorney's fees, I agree to immediately make direct payment to Valley of the Sun Institute for Pain Management of all sums (including interest) then due from the patient.

Attorney Printed Name	Phone Number

Attorney Address

Attorney Signature	Date